CONFIDENTIAL

ASSESSMENT QUESTIONNAIRE

Sharon Cohen, Naturopath
Windsor Bldg
755 Boulevard Saint-Jean, suite 606
Pointe-Claire, QC H9R 3S3
Tel : (514) 235-8900

All the information that you provide in this questionnaire will remain strictly confidential

Date: mm / dd / yy

Referral: _____

Client Information

Last Name: _____
First Name: _____

Sex: ☐ Male ☐ Female **Birthday:** mm / dd / yy **Age:** _____

Address: _____ **City:** _____ **Province:** _____ **Postal Code:** _____

Home tel.: ( ) _____ – _____

Work tel.: ( ) _____ – _____ **ext** ___

Mobile: ( ) _____ – _____

Other tel.: ( ) _____ – _____ **ext** ___

E-mail: _____

Presenting Problems

In your opinion, what are the reasons you are consulting at this time?

Describe in as much detail as possible, including what exactly the problem is, who it involves, when it began, what else was going on in your life at that time, how frequently it occurs, what bothers you most about it etc.

What do you expect out of this therapy? What are your goals?

Symptoms

What symptoms have you been experiencing lately?

Symptom	Yes	No	Comments
Physical (i.e. fatigue, pain, nausea)	☐	☐	
Mental (i.e. lack of concentration)	☐	☐	
Emotional (i.e. anger, anxiety, sadness)	☐	☐	

Stresses

List the top 3 stresses in you life right now.

1. _____

2. _____

3. _____

Medical History

Please list and explain any present or previous medical conditions.

Condition	Duration	Comments

	Yes	No	Comments
Have you ever had any surgeries?	☐	☐	
Do you have any allergies?	☐	☐	

Medical Symptoms

Do you experience any of the following common symptoms?

Symptom	Yes	No	Comments
Headaches or Migraines	☐	☐	
Vision problems	☐	☐	
Memory Lapses (Short-term or Long-term)	☐	☐	
Breathing problems (i.e. Asthma, Shortness of Breath)	☐	☐	
High Blood Pressure	☐	☐	
High Cholesterol	☐	☐	
Thyroid problems	☐	☐	
Teeth problems	☐	☐	
Liver problems	☐	☐	

Digestive problems (i.e. bloating, gas, discomfort, etc.)	☐	☐	

Symptom	Yes	No	Comment
Constipation	☐	☐	
Diarrhea	☐	☐	
Lower back pain	☐	☐	

Woman Only Section			
At what age did you begin menstruating?			
Are you post menopausal?	☐	☐	
Have you had a hysterectomy?	☐	☐	
Have you had your fallopian tubes tied?	☐	☐	
Miscarriages?	☐	☐	If more than one, please specify how many and at what age?
Abortions?	☐	☐	If more than one, please specify how many and at what age?
How many pregnancies?			
How many births?			
If you are menstruating, is your cycle: Regular? Irregular? Absent?	 ☐ ☐ ☐		
Before your			

period, do you experience : **Cramps?** **Pain?** **Migraines?** **Others?**	☐ ☐ ☐ ☐	
Before your period, do you feel? **Irritable?** **Weak?** **Depressed?**	☐ ☐ ☐	
What is the duration of your premenstrual symptoms?		

Medication/Vitamins/Supplements

Are you presently taking:	Yes	No	Please Specify Type and Dosage
Medications?	☐	☐	
Supplements?	☐	☐	
Natural products?	☐	☐	
Alcohol (wine, beer, spirits)?	☐	☐	

Recreational drugs?	☐	☐	

Diet

Describe a typical daily menu that you would eat.

Food	Yes	No	Approximately How Many Portions Per Day?
Dairy (i.e. Milk, Yogurt, Cheese, etc.)	☐	☐	
Grains (i.e. Bread, Cereal, etc.)	☐	☐	
Vegetables	☐	☐	
Fruit	☐	☐	
Meat (i.e. Beef, Chicken, Turkey, etc.)	☐	☐	
Meat Alternatives (i.e. Soy based products, tofu, etc.)	☐	☐	
Fish (i.e. Salmon, Tuna, etc.)	☐	☐	
Caffeine (i.e. Coffee, Tea, Supplements)	☐	☐	
Other	☐	☐	

Exercise

Do you exercise regularly? ☐ Yes ☐ No

How often do you exercise per week? _____

Type of Exercise	Frequency	Comments

Which exercise do you enjoy the most? _____

Sleep

How many hours do you sleep per night? _____

What time do you usually go to bed? _____

Do you have difficulty sleeping? ☐ Yes ☐ No

If so, what is the difficulty: ☐ Falling asleep ☐ Nightmares ☐ Waking up throughout the night ☐ Early Wake Up ☐ No Sleep at all

☐ Other. Specify: _____

Do you feel rested upon waking? ☐ Yes ☐ No

Explain.

Psychiatric or Psychological History

	Yes	No	Please Specify Names & Dates
Have you ever been to see a psychologist or psychiatrist before?	☐	☐	

Does your family have a psychiatric history?	☐	☐

Mood State

Using the scale below, where do you see yourself right now? (Please circle your response)

0 1 2 3 4 5 6 7 8 9 10

Happy and cheerful
Always positive

Very depressed
"I can't stand living"

0 1 2 3 4 5 6 7 8 9 10

No anxiety
Relaxed and mellow most of the time

Very Panicky
Highly Anxious

Do you presently or have you ever considered committing suicide? ☐ Yes ☐ No

If Yes, please specify.

Education

Indicate your level of education. (select all that apply)

☐ **Some high school** Grade:_____

☐ **High School Diploma**

☐ **CEGEP diploma** Program: _____

☐ **Bachelor's degree** Major: _____ Minor: _____

☐ **Master's degree** Field: _____

☐ **Doctorate** Field: _____

☐ **Trade school** Field: _____

☐ **Other** Field: _____

Work

Do you work? ☐ Yes ☐ No

Employer: _____ **Time with employer:** _____

Job Title: _____ **Hours of work per week:** __

Job description:

Do you enjoy your job? ☐ Yes ☐ No

Explain.

What part(s) of your job do you enjoy the most?

What part(s) of your job do you dislike the most?

Life Events

Think of a few life events that had a significant effect on you. (From now to childhood).

Event	Year	Effect on you

Relationships/Family History

1 2 3 4 5 6 7 8 9 10

Poor Good Excellent

Describe your relationship with your mother. Rate from 1 to 10: ____

Describe your relationship with your father. Rate from 1 to 10: ____

Describe your relationship with your siblings (if applicable).

Name	Age	Rate 1 to 10	Comments

Describe your relationship with your children (if applicable).

Name	Age	Rate 1 to 10	Comments

Do you have a romantic partner? ☐ Yes ☐ No Name:_____

	Yes	No	Comments
Are you intimate?	☐	☐	
Are you sexually active?	☐	☐	
Do you communicate well?	☐	☐	
Duration of your relationship?	☐		

Further describe your relationship with your romantic partner.

Social

Using the scale below, how do you consider your relationships with others? (Please circle your response)

1 2 3 4 5 6 7 8 9 10

Poor Neutral Excellent

Do you consider yourself to have close friends? ☐ Yes ☐ No

Explain.

List some social activities you engage in.

Social Activity	Frequency	Comments

What social activity do you enjoy the most? _____

Hobbies/Interests/Activities

List some of your hobbies, interests and activities.

Hobby/Interest/Activity	Frequency	Why do you enjoy this activity?

What hobby, interest, activity do you enjoy the most? _____

What are your sources of pleasure? _____

What do you find nourishes you? _____

What do you find depletes you?_____

Additional Information

Is there anything else you feel is important to share?

Consent and Release to Third Party

I,_____ authorize my therapist _____, to transmit the results of my assessment and/or release any pertinent information concerning my file to :
Name:_____

Address:_____

Telephone :_____

Date : _____

Signature : _____