

CONFIDENTIAL

ASSESSMENT QUESTIONNAIRE

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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)	<input type="checkbox"/>	<input type="checkbox"/>	
Mental (i.e. lack of concentration)	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional (i.e. anger, anxiety, sadness)	<input type="checkbox"/>	<input type="checkbox"/>	

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?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	

Medical Symptoms

Do you experience any of the following common symptoms?

Symptom	Yes	No	Comments
Headaches or Migraines	<input type="checkbox"/>	<input type="checkbox"/>	
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	
Memory Lapses (Short-term or Long-term)	<input type="checkbox"/>	<input type="checkbox"/>	
Breathing problems (i.e. Asthma, Shortness of Breath)	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	
Teeth problems	<input type="checkbox"/>	<input type="checkbox"/>	
Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	
Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>	

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(i.e. bloating, gas, discomfort, etc.)

Symptom	Yes	No	Comment
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
Lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	

Woman Only Section

At what age did you begin menstruating?			
Are you post menopausal?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had a hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had your fallopian tubes tied?	<input type="checkbox"/>	<input type="checkbox"/>	
Miscarriages?	<input type="checkbox"/>	<input type="checkbox"/>	If more than one, please specify how many and at what age?
Abortions?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>		
Irregular?	<input type="checkbox"/>		
Absent?	<input type="checkbox"/>		
Before your period, do you experience :	<input type="checkbox"/>		

Cramps?	<input type="checkbox"/>	
Pain?	<input type="checkbox"/>	
Migraines?	<input type="checkbox"/>	
Others?	<input type="checkbox"/>	
Before your period, do you feel?		
Irritable?	<input type="checkbox"/>	
Weak?	<input type="checkbox"/>	
Depressed?	<input type="checkbox"/>	
What is the duration of your premenstrual symptoms?		

Medication/Vitamins/Supplements

Are you presently taking:	Yes	No	Please Specify Type and Dosage
Medications?	<input type="checkbox"/>	<input type="checkbox"/>	
Supplements?	<input type="checkbox"/>	<input type="checkbox"/>	
Natural products?	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol (wine, beer, spirits)?	<input type="checkbox"/>	<input type="checkbox"/>	
Recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	

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.)	<input type="checkbox"/>	<input type="checkbox"/>	
Grains (i.e. Bread, Cereal, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	
Fruit	<input type="checkbox"/>	<input type="checkbox"/>	
Meat (i.e. Beef, Chicken, Turkey, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Meat Alternatives (i.e. Soy based products, tofu, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Fish (i.e. Salmon, Tuna, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	
Caffeine (i.e. Coffee, Tea, Supplements)	<input type="checkbox"/>	<input type="checkbox"/>	
Other	<input type="checkbox"/>	<input type="checkbox"/>	

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?	<input type="checkbox"/>	<input type="checkbox"/>	
Does your family have a psychiatric history?	<input type="checkbox"/>	<input type="checkbox"/>	

Mood State

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

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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:

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

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?