# 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) | ☐ | ☐ | |
| 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:<br>Regular?<br>Irregular?<br>Absent? | ☐<br>☐<br>☐ | | |
| Before your period, do you experience : | ☐ | | |

| | | |
|---|---|---|
| Cramps?<br>Pain?<br>Migraines?<br>Others? | ☐<br>☐<br>☐ | |
| Before your period, do you feel?<br>Irritable?<br>Weak?<br>Depressed? | ☐<br>☐<br>☐ | |
| 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?**