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New Client Questionnaire

Name:_____ Date:_____

Address:_____ City:_____ Postal Code:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email:_____

Date of Birth_____ Age:_____ Occupation (present):_____ Occupation (past):_____

Marital Status: (please mark) ☐ Married ☐ Single ☐ Divorced ☐ Common Law ☐ Re-Married

How did you hear about our office?_____

Name and Number of Family Doctor:_____

Name and Number of Other Health Care Providers:_____

Please state your primary reason for attending our clinic. Please list the first time you noticed the condition and describe any factors that you suspect may have played a role in its onset and perpetuation:

Regarding your chief concern, what treatments, (diets, therapies) if any, have brought you real improvement or relief?

What treatments, if any, have you tried that have not improved your condition?

Please list any other health concerns:

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Please list any significant illnesses that you have had in the past:

Please list any significant trauma (car accidents, injuries, emotional, etc.):

Have you ever been hospitalized? (Please indicate reason and year):

Have you experienced any significant childhood trauma/grief/stress?

Please list any drugs or supplements that you are currently taking. Include dosage:

Are you satisfied with your current weight?

Please describe the type and frequency of your exercise:

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Family History

Please indicate where applicable if anyone in your family currently has or has had any of the following conditions:

	Father	Mother	Brothers	Sisters	Grandmother		Grandfather	
					Maternal	Paternal	Maternal	Paternal
Age (if living)								
Health (G=good, P=poor)								
Anemia								
Asthma, Hayfever, Hives								
Cancer								
Cystic Fibrosis								
Diabetes								
Epilepsy								
Rheumatoid Arthritis								
Osteoarthritis								
Heart Disease/High Blood Pressure								
Kidney Disease								
Mental Illness								
Alcoholism								
Stroke								
Tuberculosis								
Other								
Age (at death)								
Cause of death								

Please indicate your frequency of use of the following:

Cigarettes/ Cigars	____/d	____/wk	____/mo	Antacids	____/d	____/wk	____/mo
Coffee	____/d	____/wk	____/mo	Drugs	____/d	____/wk	____/mo
Tea	____/d	____/wk	____/mo	Sugar	____/d	____/wk	____/mo
Pop (reg.)	____/d	____/wk	____/mo	Salt	____/d	____/wk	____/mo
Pop (diet)	____/d	____/wk	____/mo	Pain Relievers	____/d	____/wk	____/mo
Alcohol	____/d	____/wk	____/mo	TV (hrs)	____/d	____/wk	____/mo
Microwave	____/d	____/wk	____/mo	Computer (hrs)	____/d	____/wk	____/mo

Did you ever smoke? Use alcohol excessively? Use recreational drugs to excess? Please give details and quitting date:

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Do you have any allergies? (food, environmental, drug, medication...)

Did you have a flu shot this year?_____ Lifetime total?_____

Are your vaccinations up to date?_____

Do you have any pets?_____

Have you been exposed to any known toxins/hazards?_____

Do you have any pets?_____

Where do you live: (please mark) ☐ Apartment ☐ House ☐ Basement Suite

How long have you lived there?_____

How old is your home?_____

Have you done any home renovations recently?_____

Who do you live with?_____

How would you describe the emotional climate of your home?_____

What do you do in your spare time? Hobbies?