CONFIDENTIAL

ASSESSMENT QUESTIONNAIRE

To the best of your ability, please answer all of the questions. 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** **Birthdate:** mm / dd / yy **Age:** _____

Address:_____

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

Mother tongue: _____ **Other Spoken Languages:** _____

Home tel.: ( ) _____-_____

Work tel.: ( ) _____-_____ ext _____

Mobile: ( ) _____- _____

Other tel.: ( ) _____-_____ext _____

E-mail address: _____

I agree to receive periodical email correspondence from our clinic (i.e. appointment reminders and newsletters). Yes ☐

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 is the problem, 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?

Stresses

List the Top 3 stresses in your life right now.

1. _____

2. _____

3. _____

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: _____

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?	☐	☐	

Medication/Vitamins/Supplements

	Yes	No	Please Specify Type and Dosage
Are you presently taking any medications?	☐	☐	
Are you presently taking any supplements?	☐	☐	

Symptoms

Do you experience any of the following common symptoms?

Symptom	Yes	No	Comments
Migraines or migraines (specify)	☐	☐	
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…)	☐	☐	
Constipation	☐	☐	
Diarrhea	☐	☐	
Lower back pain	☐	☐	

Other aches or pains	☐	☐	
Fatigue	☐	☐	
Sleep Disturbances	☐	☐	
Restlessness	☐	☐	
Weight problems	☐	☐	
Eating problems	☐	☐	
Anger	☐	☐	
Anxiety	☐	☐	
Trouble with concentration	☐	☐	
Mood swings	☐	☐	
Irritability	☐	☐	
Sadness	☐	☐	
Loss of interest	☐	☐	
Trouble making decisions	☐	☐	
Fears (specify)	☐	☐	
Guilt	☐	☐	
Obsessive or repetitive thoughts	☐	☐	
Worry	☐	☐	
Loneliness	☐	☐	
Alcohol use	☐	☐	

Drug use	☐	☐	

Woman Only Section			**Comments**
At what age did you begin menstruating?			
Is your cycle: Regular? Irregular? Absent?	 ☐ ☐ ☐		
Before your period, do you Experience Cramps? Pain? Migraines? Irritability Weakness Depressed mood?	 ☐ ☐ ☐ ☐ ☐ ☐		
What is the duration of premenstrual symptoms?			
Do you have any gynecological conditions?	☐	☐	
Are you post menopausal?	☐	☐	
Have you had a hysterectomy?	☐	☐	
Miscarriages?	☐	☐	
Abortions?	☐	☐	
How many pregnancies? _____			
How many births? _____			

Psychological History and Mood State

Have you been to see a psychologist or psychiatrist before? **Yes** ☐ **No** ☐

If yes, therapist's name _____

Date of Last Visit _____ **Telephone** _____

Reason for Consulting at the time _____

Does your family have a psychiatric history? **No** **Yes**

If yes, please specify: _____

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

No Anxiety
Relax and mellow
most of the time

Moderate
Anxiety
Fully Functional

Very Panicky.
Highly Anxious

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

Very Depressed
Apathetic

Sad

Happy
Joyful

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

If Yes, please specify.

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?

What is your degree of overall job satisfaction?

0 1 2 3 4 5 6 7 8 9 10

Completely dislike. Waste of time — OK — Completely love it. Passionate

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	☐	☐	
Fruits	☐	☐	
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.

Life Events

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

Event	Age	Effect on you

Relationships/Family History

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

0 1 2 3 4 5 6 7 8 9 10

Poor Good Completely Satisfying

Describe your relationship with your mother. Rate from 0 to 10: ____

Describe your relationship with your father. Rate from 0 to 10: ____

Describe your relationship with your children (if applicable).

Name	Age	Rate 1 to 10	Quality

Describe your relationship with your siblings (if applicable).

Name	Age	Rate 1 to 10	Quality

Do you have a romantic partner? ☐ Yes ☐ No Name:_____
How long have you been together? _____

With your partner…	Yes	No	Comments
Are you intimate?	☐	☐	
Are you sexually active?	☐	☐	
Do you communicate well?	☐	☐	

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

Social

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

Please elaborate:

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 are your sources of pleasure?

What do you find nourishes you?

What do you find depletes you?

Other

Is there anything else you feel is important to share right now?

Consent to Release Information

In order to receive optimal care I understand that the health professionals at Sunflower Health Center use a multi-disciplinary team approach and may share pertinent information regarding my case with each other.

Signature: _____

Date:_____

I understand that the Practitioner involved in my case may need to communicate with other person(s) involved in my case (ex: physician, teacher, parent, other professionals etc.)

I authorize my Practitioner _____, to share pertinent information regarding my file specifically to:

1. _____ _____ _____ _____

Name	Relationship	Address	Phone Number

2. _____ _____ _____ _____

Name	Relationship	Address	Phone Number

3. _____ _____ _____ _____

Name	Relationship	Address	Phone Number

Signature:_____

Date:_____