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

Medication/Vitamins/Supplements

	Yes	No	Please Specify Type and Dosage
Are you presently taking any medications?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you presently taking any supplements?	<input type="checkbox"/>	<input type="checkbox"/>	

Symptoms

Do you experience any of the following common symptoms?

Symptom	Yes	No	Comments
Migraines or migraines (specify)	<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 (i.e. bloating, gas, discomfort, etc...)	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
Lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	

Assessment Questionnaire 5

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

Assessment Questionnaire 6

Drug use	<input type="checkbox"/>	<input type="checkbox"/>	
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Woman Only Section		Comments
At what age did you begin menstruating?		
Is your cycle:		
Regular?	<input type="checkbox"/>	
Irregular?	<input type="checkbox"/>	
Absent?	<input type="checkbox"/>	
Before your period, do you Experience		
Cramps?	<input type="checkbox"/>	
Pain?	<input type="checkbox"/>	
Migraines?	<input type="checkbox"/>	
Irritability	<input type="checkbox"/>	
Weakness	<input type="checkbox"/>	
Depressed mood?	<input type="checkbox"/>	
What is the duration of premenstrual symptoms?		
Do you have any gynecological conditions?	<input type="checkbox"/>	<input type="checkbox"/>
Are you post menopausal?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had a hysterectomy?	<input type="checkbox"/>	<input type="checkbox"/>
Miscarriages?	<input type="checkbox"/>	<input type="checkbox"/>
Abortions?	<input type="checkbox"/>	<input type="checkbox"/>
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...)	<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"/>	
Fruits	<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.

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?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you sexually active?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you communicate well?	<input type="checkbox"/>	<input type="checkbox"/>	

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
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2. _____

Name	Relationship	Address	Phone Number
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3. _____

Name	Relationship	Address	Phone Number
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Signature: _____

Date: _____