Date: Click here to enter a date.

First Name:  Last Name: 

Address:  City: 

Postal Code:  Email: 

Primary Contact Phone Number: 

This is a confidential record of your medical history and will be kept in this office.

Information contained here will not be released to any person except when you have authorized us in writing to do so, or when required by law.

Please complete this questionnaire as thoroughly as possible.

What symptoms are you experiencing that you suspect may have an emotional source? (Example: headaches, muscle spasms, skin rashes)

Click here to enter text.

If this is a chronic illness, how long have you had this condition?

Click here to enter text.

Have you sought treatment for this condition? Yes  No

If yes, what type of treatment did you receive? Click here to enter text.

If you are female, are you currently pregnant? Yes  No

Are there other health concerns that I should be made aware of?

Click here to enter text.

Personal Health Habits

Smoker Yes  No

If yes: Amount/day?  Years smoked?  Years stopped? 

Are you exposed to second hand smoke? Yes  No

Alcohol Use? Socially:  Moderately (1-3/daily):  Heavy (>3/day)

Cannabis use? Yes  No

If yes, how often do you partake per month? 

Caffeine use: Never:  1-2/day  >3/day

Do you exercise regularly? Yes  No

If yes, what type of exercise? 

How often do you exercise per week 1-3 times a week  >3 times a week

How many hours of sleep per night? <6 hours  6-8 hours  >8 hours

Do you wake rested? Yes  No

Describe your typical morning routine: 

What level of personal stress are you experiencing in your daily life right now?

Minimal  Average  Considerable  Unbearable

The main stressor is (mark as many as you have):

Financial  Job related  Marriage  Health

Interpersonal  Unfulfilled expectations  Family

Spiritual  Other  Please specify: 

What do you do to deal with stress? 

Anything else you’d like to add? 