



NEW CLIENT FORM

Client Information:

Name: _____ Date: _____

Place of Birth: _____ City you currently living in: _____

Please list significant moves or immigration: _____

DOB: _____ Phone (best number to reach you): _____

E-mail _____ Gender: Female/Male Dominant Hand: Right/Left

Education: _____ Years of Education: _____

Occupation: _____ Hours per week: _____ Retired: _____

Marital Status: Married___ Separated___ Divorced___ Widowed___ Single___ Partnership___

Live with: Spouse___ Partner___ Parents___ Children___ Friends___ Alone___

Do you have children? If so, how many? _____ Age(s) of children: _____ Gender of children: _____

Next of kin or other to reach in an emergency: _____ Relationship to you: _____

Phone: _____ Address: _____

Who referred you to the Centre? _____

Reason for visit? PLEASE COMPLETE THIS IN FULL

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

Client Health History:

Medical Conditions / Issues: 1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Surgical History: 1. _____ 2. _____ 3. _____

Medications (indicate dose): 1. _____ 2. _____ 3. _____

Hormones: 1. _____ 2. _____ 3. _____

Supplements: 1. _____ 2. _____ 3. _____

Please **circle** if you are currently taking any of the following:

Kavinace, GABA, Theanine, 5-HTP, Mucuna powder, Ginko Biloba, Balance D 1-3, Benesom, Brain Calm, Calm-PRT, Deproloft HF, EndoPlus Spray, EndoTrex Spray, ExcitaCor, ExcitaPlus, Lithium Orotate, L-Theanine, Melatonin, Ortho-Sleep, Pure Tranquility, Somnolin, St. John's Wort, Trancor, Tryptophan, Zen-Mind.

What are your health expectations from attending this clinic?

Are you currently undergoing any additional forms of treatment? Please comment:

IV: _____ Chelation: _____
Psychotherapy/Counselling: _____ Depth Psychology/Analysis: _____
Physiotherapy: _____ Chiropractor: _____
Acupuncture: _____ Massage: _____
Meditation: _____ Hypnosis: _____
Other: _____

Have you ever had a concussion, head injury, motor vehicle accident or sporting injury? Please include any history of bumps on the head, falls, fainting, loss of consciousness, whiplash and/or seizure. **Yes / No**

If yes, please list your **age** and describe any **symptoms** you experienced after each incident, and where any injury occurred (bruising, swelling, broken bones, dizziness, loss of consciousness, vertigo, confusion, memory loss, etc.):

Please indicate where your head was hit: _____

Do you have trouble sleeping? _____ If yes, do you have difficulty falling asleep? **Yes / No** ; Staying asleep? **Yes / No**

What time do you go to bed? _____ What time do you wake? _____ Do you feel rested in the mornings? **Y / N**

Additional comments: _____

Please list significant life stressors, when they started and how they manifested?

Please describe in full any obsessive compulsive tendencies you may have? _____

In the first 10 years of your life, were you ever separated (physically or psychologically) from your mother? (traumatic pregnancy, traumatic birth, incubator, frequent hospitalizations, holidays taken without you, etc.): _____

Would you describe your childhood as: stable and nourishing or traumatic and stressful? (please circle)

Circle how you consider your ability to cope with stress? (1 = poorly; 10 = excellently) 1 2 3 4 5 6 7 8 9 10

What methods do you use to cope with stress? _____

Do you have a history of recurrent colds or infections? (Strep throat, ear infections, sinusitis, tonsillectomy, etc.)

If applicable, are you approaching or undergoing menopause? If so, when did your symptoms first become noticeable?
And how did the symptoms manifest? _____

Do you have any allergies? (medications, food, chemicals, inhalants) Please list: _____

Do you have any dietary restrictions? Please describe: _____

How long have you been following this diet? _____

What are your diet preferences? _____

Do you have food cravings? **Yes / No** ; Please specify: _____

Do you drink: Coffee (_____ cups/d); Tea (green or black) (_____ cups/d); Energy drinks (_____/d)

When was the last time you consumed a caffeinated beverage? _____ (hours)

If you drink alcoholic beverages, what is your preference? Wine/Beer/Spirits _____

On average, how many alcoholic drinks do you consume per week? _____

Do you smoke? **Yes / No** ; If yes, on average how many cigarettes do you smoke per week? _____

Do you use recreational drugs? **Yes / No** ; Please specify type and frequency: _____

Do you exercise? **Yes / No** ; If yes, how often? (days per week) _____

What physical activities do you participate in? _____

Do you have any recreational hobbies? **Yes / No** ; Please list: _____

How frequently do you socialize with peers? _____ With family? _____

On average, how many hours do you spend watching TV per day? _____

On average, how many hours do you spend in front of a computer/telephone/tablet per day? _____

On the chart below, please check any of the following symptoms or behaviors that you have experienced in the last two weeks and circle the symptom that applies the most in each group.

| | | | |
|--|--|--|--|
| AN | | LD | |
| Anxious, uneasy, worried | | Confused, mixed up thinking | |
| Racing thoughts, too many thoughts | | Difficulty reading | |
| Explosive rage/anger, lashing out | | Difficulties with math | |
| Aggressive, hostile, overly assertive | | FI/PA | |
| Agitated, upset, disturbed | | Teeth grinding, jaw clenching, TMJ | |
| Hyper focused, "locked in" on one thing | | Tic (eye, mouth, other) spasms | |
| Nauseous, queasy, or upset stomach | | Migraine headaches | |
| CO | | Physical tensions in body, taut, tense | |
| Difficulty making decisions | | Pressure in chest, discomfort in chest | |
| Spacey, foggy, not "tuned in" | | Unpleasant physical sensations, pain | |
| Hyperactive, excessive movement | | Tension headaches | |
| Inattentive, daydreaming, distracted | | Crawling sensation on skin, leg twitches | |
| Impulsive, act without thinking | | ME | |
| DE | | Difficulty grasping new information | |
| Feelings easily hurt, overly sensitive | | Forgetful, difficulty remembering | |
| Depressed, hopeless, sad | | IN | |
| Cries easily, weepy, prone to tears | | Difficulty falling asleep | |
| Low self-esteem, lacking self-confidence | | Disturbed sleep, wake often | |
| Unable to plan, organize or manage time | | Gasping for breath | |
| Lethargic, drowsy, slow moving | | Restless legs | |

If you have any additional symptom or concerns, please list them here:
