Douglas Caird
Intuitive Holistic Therapy

Original Date:
Dates Revised:

CLIENT INTAKE QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical/treatment record.

The questionnaire is designed to provide your Therapist with all the information necessary to build an individual treatment programme tailored to your needs. Please answer the questions as accurately as you can, giving detailed information where possible.

Name: ☐ M ☐ F	**DOB:**
Address and Postcode:	
Telephone Number(s): **Email Address:**	
GP Name:	
Surgery Address and Postcode: **Telephone Number:**	
☐ Please tick here if you want to be added to my mailing list for my Newsletter, events, offers and workshops, etc.	

HEALTH PROFILE

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations and dates: (if known)	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenz	☐ MMR *Measles, Mumps, Rubella*

List any diagnosed medical problems:

Surgeries:

Year	Reason	Hospital

Other hospitalisations:

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No
If Yes, give reason:		

List any prescribed medication and any supplements taken, such as vitamins and minerals:		
Medication	Strength	Frequency Taken
Allergies to medications and any other known allergies:		
Medication	Reaction You Had	

HEALTH HABITS AND LIFESTYLE

Exercise:	☐ Sedentary (No exercise)					
	☐ Mild exercise					
	☐ Occasional vigorous exercise					
	☐ Regular vigorous exercise					
Diet:	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a prescribed medical diet?				☐ Yes	☐ No
	Number of meals you eat in an average day?					
	Salt intake:	☐ High	☐ Medium	☐ Low		
	Fat intake:	☐ High	☐ Medium	☐ Low		
Caffeine:	☐ None	☐ Coffee	☐ Tea	☐ Other drinks containing caffeine		
Alcohol:	Do you drink alcohol?				☐ Yes	☐ No
Water:	Do you drink natural, un-flavoured, un-carbonated water?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

Relative	Age	Significant Health Problems	Relative	Age	Significant Health Problems
Father:			**Children:**	☐ M ☐ F	
Mother:				☐ M ☐ F	
Sibling:	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather:** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather:** *Paternal*		

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a Counsellor?	☐ Yes	☐ No

WOMEN ONLY

Are you pregnant or currently trying to conceive?	☐ Yes	☐ No
Have you had or are currently receiving any treatment/s for infertility issues?	☐ Yes	☐ No
Are you breastfeeding?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No

OTHER PROBLEMS

Cardiovascular:	Mental/Emotional:	Adrenal and Immunity:
☐ Heart disease	☐ Depression	☐ Chronic Fatigue Syndrome
☐ High blood pressure	☐ Anxiety	☐ General fatigue
☐ Low blood pressure	☐ Nervousness	☐ Frequent infections
☐ Chest pain	☐ Panic attacks	☐ Allergies
☐ Palpitations	☐ Mood swings	☐ Easy bruising
☐ Stroke	☐ Irritability	☐ Fibromyalgia
☐ Varicose veins	☐ Memory decline	☐ Auto-immune disease
☐ Edema	☐ Other	☐ Other
☐ Other		
Endocrine:	**Musculo-Skeletal:**	**Gastro-Intestinal:**
☐ Hypothyroid	☐ Neck/shoulder pain	☐ Stomach ulcers
☐ Hyperthyroid	☐ Muscle cramps/spasms	☐ Appetite changes
☐ Hypoglycemia	☐ Back pain	☐ Nausea/vomiting
☐ Diabetes Type I	☐ Osteoporosis	☐ Abdominal pain
☐ Diabetes Type II	☐ Arthritis	☐ Passing wind
☐ Night sweats	☐ Joint pain	☐ Heartburn
☐ Feeling Hot/Cold	☐ Other	☐ Burping
☐ Hormonal imbalance		☐ Gallstones
☐ Other		☐ Constipation
		☐ Diarrhoea
		☐ Bloating

Urinary:	Neurological:	Head and ENT:
☐ Kidney disease	☐ Vertigo	☐ Headaches
☐ Kidney stones	☐ Dizziness	☐ Migraine
☐ Painful urination	☐ Epilepsy/seizures	☐ Dry, irritable eyes
☐ Frequent UTIs	☐ Loss of balance	☐ Tearing eyes
☐ Frequent urination	☐ Numbness/tingling	☐ TMJ/Jaw problems
☐ Urgent urination	☐ Other:	☐ Tinnitus
☐ Incontinence		☐ Sinus infections
☐ Dark urine		☐ Other
☐ Other:		

Sleep:	Emotional/Stress/Anxiety:	Other:
☐ Restless sleep	Current stress level: ☐VH…☐H…☐M…☐L	☐ Cancer
☐ Insomnia	**Predominant emotion right now:**	☐ Candida
☐ Excessive sleeping	☐ Anxiety/worry	☐ Eczema/hives
☐ Busy dreams	☐ Fear	☐ Cold hands/feet
☐ Floating feeling before falling asleep	☐ Anger	☐ Thin, Graying hair
☐ Other:	☐ Grief	☐ Aversion to cold
	☐ Apathy/numbness	☐ Aversion to heat
	☐ Depression	☐ Other:
	☐ Contentment	
	☐ Joy	
	☐ Other:	

How are you feeling today, right now?

Have you had any accidents in your life that you can remember? If yes, please give details and treatment/outcome:

What do you hope to achieve from your Therapy?

Any other relative information:

Signature and Date:

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