

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:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Address and Postcode:		
Telephone Number(s):		
Email Address:		
GP Name:		
Surgery Address and Postcode:		
Telephone Number:		
<input type="checkbox"/> 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:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio	
Immunizations and dates: (if known)	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chickenpox
	<input type="checkbox"/> Influenza	<input type="checkbox"/> MMR <i>Measles, Mumps, Rubella</i>
List any diagnosed medical problems:		
Surgeries:		
Year	Reason	Hospital
Other hospitalisations:		
Year	Reason	Hospital
Have you ever had a blood transfusion?		<input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Sedentary (No exercise)				
	<input type="checkbox"/> Mild exercise				
	<input type="checkbox"/> Occasional vigorous exercise				
	<input type="checkbox"/> Regular vigorous exercise				
Diet:	Are you dieting?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you on a prescribed medical diet?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Number of meals you eat in an average day?				
	Salt intake:	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low	
	Fat intake:	<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low	
Caffeine:	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Other drinks containing caffeine	
Alcohol:	Do you drink alcohol?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Water:	Do you drink natural, un-flavoured, un-carbonated water?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

Relative	Age	Significant Health Problems	Relative	Age	Significant Health Problems
Father:			Children:	<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Mother:				<input type="checkbox"/> M	
				<input type="checkbox"/> F	
Sibling:	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F			<input type="checkbox"/> F	
	<input type="checkbox"/> M			Grandmother	
	<input type="checkbox"/> F			<i>Maternal</i>	
	<input type="checkbox"/> M			Grandfather:	
	<input type="checkbox"/> F			<i>Maternal</i>	
<input type="checkbox"/> M			Grandmother		
<input type="checkbox"/> F			<i>Paternal</i>		
<input type="checkbox"/> M			Grandfather:		
<input type="checkbox"/> F			<i>Paternal</i>		

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

WOMEN ONLY

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

OTHER PROBLEMS

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

Urinary:	Neurological:	Head and ENT:
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Headaches
<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Migraine
<input type="checkbox"/> Painful urination	<input type="checkbox"/> Epilepsy/seizures	<input type="checkbox"/> Dry, irritable eyes
<input type="checkbox"/> Frequent UTIs	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Tearing eyes
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Numbness/tingling	<input type="checkbox"/> TMJ/Jaw problems
<input type="checkbox"/> Urgent urination	<input type="checkbox"/> Other:	<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Incontinence		<input type="checkbox"/> Sinus infections
<input type="checkbox"/> Dark urine		<input type="checkbox"/> Other
<input type="checkbox"/> Other:		
Sleep:	Emotional/Stress/Anxiety:	Other:
<input type="checkbox"/> Restless sleep	Current stress level: <input type="checkbox"/> VH... <input type="checkbox"/> H... <input type="checkbox"/> M... <input type="checkbox"/> L	<input type="checkbox"/> Cancer
<input type="checkbox"/> Insomnia	Predominant emotion right now:	<input type="checkbox"/> Candida
<input type="checkbox"/> Excessive sleeping	<input type="checkbox"/> Anxiety/worry	<input type="checkbox"/> Eczema/hives
<input type="checkbox"/> Busy dreams	<input type="checkbox"/> Fear	<input type="checkbox"/> Cold hands/feet
<input type="checkbox"/> Floating feeling before falling asleep	<input type="checkbox"/> Anger	<input type="checkbox"/> Thin, Graying hair
<input type="checkbox"/> Other:	<input type="checkbox"/> Grief	<input type="checkbox"/> Aversion to cold
	<input type="checkbox"/> Apathy/numbness	<input type="checkbox"/> Aversion to heat
	<input type="checkbox"/> Depression	<input type="checkbox"/> Other:
	<input type="checkbox"/> Contentment	
	<input type="checkbox"/> Joy	
	<input type="checkbox"/> 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 session/s with Douglas Caird?

Declaration:

I declare the information provided above to be true to the best of my knowledge.

In addition, I understand, accept and agree the following:

- **Our core agreement for giving and receiving during any session is one of mutual consent unless otherwise voiced. In this respect, therefore, it is wholly my duty during any session to take complete responsibility for my own safety, wellbeing and comfort.**
- **If there is anything that I am not happy with; if I need anything; if I want to change anything; if I want to stop; if I want to share anything which I think may be of importance or relevance to any session, or not, it is my responsibility to communicate this clearly, either verbally or otherwise.**
- **I have read and understand the Terms and Conditions at www.douglascaird.co.uk.**

Any other relative information:

Signature and Date:



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