



Health Questionnaire

Today's Date: _____

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Mailing Address: _____

City or Town: _____ Prov: _____ Postal Code: _____

Phone Number: _____ Alt. Phone No: _____

I send out e-mail newsletters about once a month. Would you like to join the list? Yes
(You can unsubscribe at any time.)

E-mail Address: _____

Dr. Name: _____ Clinic: _____

Date of last visit: _____

Are you presently taking any medications: Yes No

If yes, reason for taking? _____

Have you ever received any type of mental health services (psychotherapy, psychiatric services, etc)?
 Yes No If yes, who was your practitioner: _____

Have you ever been prescribed psychiatric medication: Yes No

If yes, please list and provide dates: _____

Current Occupation: _____ No. of years: _____

If retired, what was your main line of work? _____

Do you enjoy your work? _____

Are you currently experiencing any chronic pain: Yes No

If yes, please describe: _____

Do you sleep well? Yes No

If no, can you describe your sleeping pattern? _____

Are you currently experiencing anxiety, panic attacks or have phobias? Yes No

Overwhelming sadness, grief or depression? Yes No

If yes when did it begin? _____

Do you have allergies or sinus conditions? Yes No

List: _____

Is your blood pressure: High Normal Low

Does your doctor say you have heart disease? Yes No

Are you diabetic? Type I Type II Not Diabetic

Are you pregnant? Yes No If so what trimester? _____

Do you have any children? Yes No

Marital status: Happily Married Married Divorced Widowed Single

Have you ever had an epileptic episode? Yes No

If yes, how long ago? _____

Have you ever had a serious injury, accident or fall? Yes No

Details if yes: _____

In the last 6 months have you had a severe blow to the head or neck injury? Yes No

In the past year have you had any of the following:

Stroke Aneurism Spinal tap or Epidural Severe blow to the head

If so, how long ago? _____

Do you drink alcohol more than once a week? Yes No

If you engage in recreational drugs use, how often do you use?

Never Infrequently Monthly Weekly Daily

Is there anything about your health or life issues you would like to mention:

Consent to receive treatment:

By signing this form I consent to receive treatment(s) given to me.

I understand Grace cannot medically diagnose and that these treatments
are **NOT a replacement for medical attention.**

Signature: _____

Date: _____