VANESSA YOUSSEF, BSc (Kine), ND
Madison Clinic • 4950 Yonge St, Concourse Level, Unit 2 • Toronto, Ontario • M2N 6K1 •
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NEW CLIENT QUESTIONNAIRE

Name			Date
Birth Date d d / m m / y y y y	Age	Home	Work
Address			Cell
City		Province	Postal Code
Marital Status o single o common-law o married o divorced o widowed o re-married			
Occupation – present		Occupation – past	
Family Doctor		Other Health Care Practitioners	
Email Address:			

Please state your primary reason for attending our clinic. Please list the first time you noticed the condition and describe any factors that you suspect may have played a role in its onset and perpetuation.

Regarding your chief concern, have any treatments, diets or therapies brought you real improvement or relief?

Please list any other health concerns.

1 _____

2 _____

3 _____

Please list any significant illnesses that you have had in the past.

1 _____

2 _____

3 _____

Have you ever been hospitalized? Please indicate reason and year.

Any significant adult trauma, grief or stress (e.g. accidents, falls, emotional, etc.)?

Any significant childhood trauma, grief or stress?

Please list all drugs and/or supplements that you are currently taking. Include dosage.

Please describe the type and frequency of your exercise.

Please indicate your frequency of use of the following.

Alcohol	_____	○ day	○ week	○ month	Pop (regular)	_____	○ day	○ week	○ month
Antacids	_____	○ day	○ week	○ month	Pop (diet)	_____	○ day	○ week	○ month
Cigarettes/Cigars	_____	○ day	○ week	○ month	Salt	_____	○ day	○ week	○ month
Coffee	_____	○ day	○ week	○ month	Sugar	_____	○ day	○ week	○ month
Drugs	_____	○ day	○ week	○ month	Tea	_____	○ day	○ week	○ month
Microwave	_____	○ day	○ week	○ month	TV (hrs)	_____	○ day	○ week	○ month
Pain Relievers	_____	○ day	○ week	○ month	Computer (hrs)	_____	○ day	○ week	○ month

Did you ever smoke? Use alcohol excessively? Use recreational drugs to excess? Please give details and when you quit:

Do you have any allergies (i.e. food, environmental, drug, etc)?

Did you have a flu shot this year? ○ YES ○ NO How many times total? _____

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Have you received any other vaccinations in the last 5 years? ○ YES ○ NO

Which ones and when?

_____

_____

Do you have any pets (include number and type)?

_____

_____

Where do you live? ○ Apartment ○ House How long have you lived there? _____

How old is your home? _____ Have you done any renovations recently? _____

Who do you live with? _____

What do you do in your spare time? Any hobbies?

_____

_____

Family History

Please indicate, where applicable, if anyone in your family currently has or has had any of the following conditions:

	Father	Mother	Brothers	Sisters	Maternal		Paternal	
					G.Mother	G.Father	G.Mother	G.Father
Age (if living)								
Health (G=good, P=poor)								
Anemia								
Asthma, Hayfever, Hives								
Cancer								
Cystic Fibrosis								
Diabetes								
Epilepsy								
Rheumatoid Arthritis								
Osteoarthritis								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Mental Illness								
Alcoholism								
Stroke								
Tuberculosis								
Other								
Cause of Death								
Age (at death)								

CONFIDENTIAL HEALTH APPRAISAL

For the following, please place a ✓ in the space if you currently have the symptom, a **P** if it has been a problem in the past.

VITALITY

_____ Low stamina
_____ Low ambition
_____ Fatigue
_____ Energy drop during the day
_____ When?
_____ Poor Sleep
_____ Insomnia
_____ Feel un-refreshed on waking
_____ Unexplained weight gain/loss

HAIR

_____ Thin
_____ Excess loss
_____ Graying
_____ Excess growth
_____ Prematurely gray
_____ Grows slowly
_____ Thinning eyebrows, underarm, pubic hair

SKIN / NAILS

_____ Dryness/Cracking
_____ Itching
_____ Pimples/ Acne
_____ Boils
_____ Blotchy/ White Patches
_____ Eczema
_____ Psoriasis
_____ Dandruff
_____ Increased pigmentation
_____ Easy bruising
_____ Spots on nails
_____ Nails brittle/ split
Bite nails
_____ Fungal infection of nails

EYES

_____ Watering
_____ Burning
_____ Redness
_____ Dryness
_____ Discharge
_____ Itching

EYES

_____ Double vision
_____ Blurring
_____ Sensitive to light
_____ Cataracts
_____ Glaucoma
_____ Failing vision
_____ Frequent conjunctivitis/ styes
_____ Spots in front of eyes
_____ Dark circles under eyes

EARS

_____ Loss of hearing
_____ Ringing in the ears
_____ Wax build up
_____ Frequent earaches

NOSE

_____ Itching
_____ Loss of smell
_____ Discharge
_____ Sneezing
_____ Sinusitis
_____ Polyps
Prone to nose bleeds

MOUTH / LIPS

_____ Jaw clicks
_____ Cold sores
_____ Lips cracking
_____ Canker sores
_____ Peculiar taste in mouth
_____ Bad breath
_____ Impaired taste/ smell

TEETH

_____ Cavities
_____ Loose teeth
_____ Dentures/ Bridges
_____ Root canal
_____ Sensitivity to hot/cold
_____ Bleeding gums
_____ Gum disease

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TEETH

_____ Grinding teeth
_____ Braces

RESPIRATION

_____ Hayfever
_____ Asthma
_____ Coughing
_____ Bronchitis
_____ Shortness of breath
_____ Frequent sore throats
_____ Frequent colds/ coughs
_____ Phlegm
_____ Pneumonia

CIRCULATION / BLOOD

_____ Dizziness
_____ Cold hands/ feet
_____ Swelling hands/ feet
_____ Varicose veins
_____ Low/ high blood pressure
_____ Anemia
_____ Fainting

CARDIOVASCULAR

_____ Heart disease
_____ Palpitations
_____ Angina
_____ Heart murmurs
_____ Chest pain/heaviness

MUSCULO-SKELETAL

_____ Weakness
_____ Stiffness
_____ Aches
_____ Twitching
_____ Cramps
_____ Numbness/tingling
_____ Prone to sprains
_____ Joint pain
_____ Joint swelling
_____ Bursitis
_____ Arthritis
_____ Unsteady/lose balance

NEUROLOGICAL

_____ Headaches
_____ Migraines
_____ Forgetfulness
_____ Convulsions / seizures

GASTRO - INTESTINAL

_____ Poor appetite
_____ Large appetite
_____ Heartburn
_____ Indigestion
_____ Belching
_____ Excessive flatulence
_____ Bloating after eating
_____ Nausea/ Vomiting
_____ Ulcer
_____ Constipation
_____ Diarrhea
_____ Hemorrhoids
_____ Cravings
_____ Strong thirst
_____ No thirst
_____ Stomach pain, burning, aching after eating
_____ Digestive problems subside with rest
_____ Hungry shortly after eating
_____ Anal itching
_____ Pain under right side of rib cage
_____ Fatty foods cause indigestion
_____ History of worms/parasites
_____ Number of daily bowel movements

URINATION

_____ Dribbling
_____ Difficult
_____ Increased frequency of urination
_____ Blood in urine
_____ Painful urination
_____ Urination at night
_____ Unable to hold urine
_____ Kidney stones
_____ Bladder infection

FOR MALES

_____ Frequent / urgent urination
_____ Weak / delayed urinary stream
_____ Urge to urinate several times per night
_____ Dripping after urination
_____ Lack of sex drive
_____ Impotence
_____ Difficulty attaining / maintaining erection
_____ Painful testicles
_____ Genital rash
_____ Low sperm count
_____ Low sperm motility

FOR FEMALES

_____ Age at first period
_____ Length of cycle
_____ Length of period
_____ Irregular periods
_____ Bleeding between periods
_____ Menstrual clots
_____ Breast tenderness
_____ Irritability / mood swings
_____ Bloating during period
_____ Vaginal discharge
_____ Ovarian cysts
_____ Uterine fibroids
_____ Venereal disease
_____ Breast lumps
_____ Yeast infections
_____ Menopause
_____ Number of pregnancies
_____ Number of live births
_____ Type of birth control

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