

# Client Questionnaire

## Patient Information

Patient Name:

Date of Birth:

Gender:            Male            Female            Others (specify):

Address:

Phone Number:

Email Address:

Preferred Method of Contact:

## Medical History

1. Do you have any chronic medical conditions?            Yes            No

If yes, please list:

2. List any surgeries you have had and their dates:

3. Are you currently taking any medications or supplements?            Yes            No

If yes, please list:

4. Have you ever been hospitalized for a medical condition?            Yes            No

If yes, please provide details:

5. Do you have any allergies?	Yes	No
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If yes, please specify:

### Current Health Status

1. Please describe your reason for visiting us today:

2. How would you rate your overall health currently

3. Are you experiencing any specific symptoms or concerns?	Yes	No
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If yes, please describe:

4. On a scale of 1 to 10, how would you rate the severity of your symptoms? (1 being mild, 10 being severe):

### Family History

Are there any significant medical conditions in your family history?	Yes	No
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If yes, please specify:

### Lifestyle and Habits

1. Do you smoke?	Yes	No
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If yes, how many cigarettes per day:

2. Do you consume alcohol?	Yes	No
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If yes, how many drinks per week:

3. Do you exercise regularly?	Yes	No
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If yes, please describe your exercise routine:

4. How would you describe your diet?

**Additional Information**

1. Are you currently pregnant or breastfeeding?                      Yes                      No

If yes, please provide details:

2. Is there anything else you think we should know about your health or medical history?

**Consent and Privacy**

I authorize the healthcare provider to use my information for the purpose of providing healthcare services.

Signature:

Date: