Client Questionnaire

Patient information	
Name:	
Date of birth:	**Gender:**
Marital status:	**Occupation:**
Address:	
Phone number:	**Email:**
Preferred method of contact:	
Emergency contact name:	
Emergency contact number:	
Medical history	
Do you have any chronic medical conditions? ◯ Yes ◯ No	If yes, please specify.
List any surgeries or hospitalizations you have had and their dates (MM/YY):	**List any current medications or supplements:**
List any allergies:	**List any major medical conditions in your family:**

Current health status

Please describe your reason for visiting us today:

How would you describe your overall health currently?

Are you experiencing any specific symptoms or concerns?

On a scale from 1 to 10, where 1 is mild and 10 is severe, how would you rate pain/symptom severity?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Lifestyle and habits

Do you smoke?

◯ Yes

◯ No

If yes, how many cigarettes per day?

Do you consume alcohol?

◯ Yes

◯ No

If yes, how many drinks per week?

Do you exercise regularly?

◯ Yes

◯ No

If yes, briefly describe your exercise routine:

How would you describe your diet?

Additional information

Are you currently pregnant or breastfeeding?

◯ Yes ◯ No ◯ N/A

Is there anything else we should know about your health or medical history?

Notes:

Consent and privacy

I, _____[Name of patient]_____ authorize _____[Healthcare provider]_____ to use my information for the purpose of providing healthcare services.

Signature:	**Date:**

The following section is for use after your appointment.

Feedback	
How was your experience today? Please rate the care you received today from 1 to 10, 1 being terrible and 10 being exceptional. Provide details:	
Have you seen any other healthcare provider for this problem before? If so, how was your experience there?	
Do you have any other feedback for us today?	
Healthcare provider information	
Name:	
Signature:	**License number:**