Complete Balance Health Centre
2896 Bloor Street West
Toronto, ON, M8X 1B5
(416) 769-1163

Today's Date: _____

First Name		**Last Name**			
Address		**City**		**Postal Code**	
DOB		**Email**			

Home Phone: _____ May we leave a message? □ Yes □ No

Cell/Other Phone: _____ May we leave a message? □ Yes □ No

Physician: _____ **Address:** _____ **Phone:** _____
Employer: _____**Occupation**_____
How did you hear about us? ☐Friend ☐Internet ☐Phone Book ☐Sign ☐Other: _____
Name of Guardian if Applicable: _____
Emergency Contact: _____ **Relation:** _____ **Phone:** _____

Marital Status: □ Never Married □ Partnered □ Married □ Separated □ Divorced □ Widowed

Number of Children: _____ **Are you a smoker? YES NO**

Lifestyle:
Special Interest:_____ Sports:_____
Hobbies:_____ Health Goal: _____
Number of Hours per Week: _____

☐Coffee ☐No ☐Yes _____ cups/day
☐Tea ☐No ☐Yes _____ cups/day
☐Cigarettes ☐No ☐Yes _____ x/day
☐Alcohol ☐No ☐Yes _____ x/week
☐Exercise ☐No ☐Yes _____ x/week

What type of exercise:_____
_____
Medications /Vitamins/ Herbal Supplements?
Types and dosages: _____
_____
_____

Have you received the following services before?
☐massage therapy
☐chiropractic
☐naturopathy
☐foot care
☐orthotics
☐psychotherapy □No □Yes If yes, previous therapist's name
_____

1). Are you currently taking prescribed psychiatric medication (antidepressants or others)? □Yes □No

If Yes, please list: _____

2). Do you or your partner has insurance that covers counseling? □ Me □ My partner □ No Insurance

3). Are you currently employed? □ No □ Yes If yes, what is your current employment situation?

_____

4). Do you enjoy your work? □ No □ Yes Is there anything stressful about your current work?

_____

5). Do you consider yourself to be spiritual or religious □ Yes □ No?

If yes, describe your faith or belief:

_____

6). In the last year, have you experienced any significant life changes or stressors?

_____
_____
_____

7). What is the reason for seeking counseling/psychotherapy/life-coaching?

_____
_____
_____

8). Have you ever experienced:

Extreme depressed mood:	□ No □ Yes	Wild Mood Swings:	□ No □ Yes
Extreme Anxiety/Panic Attack:	□ No □ Yes	Sleep Disturbances:	□ No □ Yes
Phobias/Fear:	□ No □ Yes	Alcohol/Substance Abuse:	□ No □ Yes
Eating Disorder:	□ No □ Yes	Body Image Problems:	□ No □ Yes
Repetitive Thoughts/Behaviors:	□ No □ Yes	Suicide Attempt:	□ No □ Yes

9). How serious do you consider you present concerns? □ Not at all □ Mildly □ Highly

10). How motivated are you to resolve them? □ Not at all □ Mildly □ Highly

11). How optimistic are you that your concerns can be resolved? □ Not at all □ Mildly □ Highly