LISTENING, LEARNING DEVELOPMENT CENTRE

NEW CLIENT FORM

Client Information:

Name: ______________________________ Date: ______________________

Place of Birth: ______________________ City you currently living in: ______________________

Please list significant moves or immigration: ______________________________

DOB: ____________________ Phone (best number to reach you): ______________________

E-mail ______________________________ Gender: Female/Male Dominant Hand: Right/Left

Education: ______________________________ Years of Education: ____________

Occupation: ______________________ Hours per week: ______ Retired: ________

Marital Status: Married___ Separated___ Divorced___ Widowed___ Single___ Partnership___

Live with: Spouse___ Partner___ Parents___ Children___ Friends___ Alone___

Do you have children? If so, how many? ________ Age(s) of children: ___________ Gender of children: _____________

Next of kin or other to reach in an emergency: ______________________ Relationship to you: ______________

Phone: ____________________ Address: ______________________________

Who referred you to the Centre? ______________________________

Reason for visit? PLEASE COMPLETE THIS IN FULL

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Client Health History:

Medical Conditions / Issues: 1. ____________ 2. ____________ 3. ____________
4. ____________ 5. ____________ 6. ____________

Surgical History: 1. ____________ 2. ____________ 3. ____________

Medications (indicate dose): 1. ____________ 2. ____________ 3. ____________

Hormones: 1. ____________ 2. ____________ 3. ____________

Supplements: 1. ____________ 2. ____________ 3. ____________

Please **circle** if you are currently taking any of the following:

Kavinace, GABA, Theanine, 5-HTP, Mucuna powder, Ginko Biloba, Balance D 1-3, Benesom, Brain Calm, Calm-PRT, Deproloft HF, EndoPlus Spray, EndoTrex Spray, ExcitaCor, ExcitaPlus, Lithium Orotate, L-Theanine, Melatonin, Ortho-Sleep, Pure Tranquility, Somnolin, St. John's Wort, Trancor, Tryptophan, Zen-Mind.

What are your health expectations from attending this clinic?

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Are you currently undergoing any additional forms of treatment? Please comment:

IV: ____ Chelation: ____

Psychotherapy/Counselling: ___________________ Depth Psychology/Analysis: _____________________________

Physiotherapy: ______________________________ Chiropractor: ____

Acupuncture: _______________________________ Massage: ____

Meditation: _________________________________ Hypnosis: ____

Other: ____

Have you ever had a concussion, head injury, motor vehicle accident or sporting injury? Please include any history of bumps on the head, falls, fainting, loss of consciousness, whiplash and/or seizure. **Yes / No**

If yes, please list your **age** and describe any **symptoms** you experienced after each incident, and where any injury occurred (bruising, swelling, broken bones, dizziness, loss of consciousness, vertigo, confusion, memory loss, etc.):

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____

Please indicate where your head was hit:____

Do you have trouble sleeping? ______ If yes, do you have difficulty falling asleep? **Yes / No** ; Staying asleep? **Yes / No**

What time do you go to bed? ________ What time do you wake? _________ Do you feel rested in the mornings? **Y / N**

Additional comments: ____

Please list significant life stressors, when they started and how they manifested?

____

____

____

Please describe in full any obsessive compulsive tendencies you may have?______________ ____________________

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____

In the first 10 years of your life, were you ever separated (physically or psychologically) from your mother? (traumatic pregnancy, traumatic birth, incubator, frequent hospitalizations, holidays taken without you, etc.): __________________

____

____

Would you describe your childhood as: stable and nourishing or traumatic and stressful? (please circle)

____

Circle how you consider your ability to cope with stress? (1 = poorly; 10 = excellently) 1 2 3 4 5 6 7 8 9 10

What methods do you use to cope with stress? ____

____

Do you have a history of recurrent colds or infections? (Strep throat, ear infections, sinusitis, tonsillectomy, etc.)

___

If applicable, are you approaching or undergoing menopause? If so, when did your symptoms first become noticeable? And how did the symptoms manifest? ___

___

___

Do you have any allergies? (medications, food, chemicals, inhalants) Please list: ___

___

___

Do you have any dietary restrictions? Please describe: ___

___

___

How long have you been following this diet? ___

What are your diet preferences? ___

Do you have food cravings? **Yes / No** ; Please specify: ___

Do you drink: Coffee (_________ cups/d); Tea (green or black) (________ cups/d); Energy drinks (__________/d)

When was the last time you consumed a caffeinated beverage? ___ (hours)

If you drink alcoholic beverages, what is your preference? Wine/Beer/Spirits ___

On average, how many alcoholic drinks do you consume per week? ___

Do you smoke? **Yes / No** ; If yes, on average how many cigarettes do you smoke per week? ___

Do you use recreational drugs? **Yes / No** ; Please specify type and frequency: ___

Do you exercise? **Yes / No** ; If yes, how often? (days per week)___

What physical activities do you participate in? ___

___

Do you have any recreational hobbies? **Yes / No** ; Please list: ___

___

How frequently do you socialize with peers? ___ With family? ___

On average, how many hours do you spend watching TV per day? ___

On average, how many hours do you spend in front of a computer/telephone/tablet per day? ___

On the chart below, please **check** any of the following symptoms or behaviors that you have experienced **in the last two weeks** and **circle** the symptom that applies the most in each group.

AN		**LD**	
Anxious, uneasy, worried		Confused, mixed up thinking	
Racing thoughts, too many thoughts		Difficulty reading	
Explosive rage/anger, lashing out		Difficulties with math	
Aggressive, hostile, overly assertive		**FI/PA**	
Agitated, upset, disturbed		Teeth grinding, jaw clenching, TMJ	
Hyper focused, “locked in” on one thing		Tic (eye, mouth, other) spasms	
Nauseous, queasy, or upset stomach		Migraine headaches	
CO		Physical tensions in body, taut, tense	
Difficulty making decisions		Pressure in chest, discomfort in chest	
Spacey, foggy, not “tuned in”		Unpleasant physical sensations, pain	
Hyperactive, excessive movement		Tension headaches	
Inattentive, daydreaming, distracted		Crawling sensation on skin, leg twitches	
Impulsive, act without thinking		**ME**	
DE		Difficulty grasping new information	
Feelings easily hurt, overly sensitive		Forgetful, difficulty remembering	
Depressed, hopeless, sad		**IN**	
Cries easily, weepy, prone to tears		Difficulty falling asleep	
Low self-esteem, lacking self-confidence		Disturbed sleep, wake often	
Unable to plan, organize or manage time		Gasping for breath	
Lethargic, drowsy, slow moving		Restless legs	

If you have any additional symptom or concerns, please list them here:

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