Date: _____

Name: _____

Date of birth: _____

CLARENCE-ROCKLAND
FAMILY HEALTH TEAM

# Questionnaire for Interdisciplinary Services

**Desired Service(s):**

- ☐ Dietitian / Nutrition
- ☐ Counseling in Physical Activity & Exercise
- ☐ Arthritis & Fibromyalgia
- ☐ Falls Prevention
- ☐ Mental Health
- ☐ Information Sessions

**Please specify the main reason why you wish to receive services:**

**Nutrition**

- ☐ Weight Management
- ☐ Diabetes
- ☐ Digestion Issues
- ☐ Nutrition in children
- ☐ Nutrition in the elderly

**Physical Activity & Exercise**

- ☐ Joint Pain
- ☐ Weight Management
- ☐ Chronic Disease Management
- ☐ Physical Conditioning
- ☐ Falls Prevention

**Mental Health**

- ☐ Anxiety
- ☐ Depression
- ☐ Stress
- ☐ Addiction
- ☐ Grief
- ☐ Trauma

**Other:** _____

**Group Information Sessions**

- ☐ Sleep Management
- ☐ Managing Chronic Pain
- ☐ Managing Anxiety in Children
- ☐ Stress Management
- ☐ Motivation and Energy
- ☐ The Science of Weight
- ☐ Exercise Program

| What are you currently doing to cope with your difficulties? |
|---|
| |
| |
| |

Do you have support from your family and friends? ☐ Yes ☐ No

Do you have transportation? ☐ Yes ☐ No

Do you have Private Health Insurance? ☐ Yes ☐ No

Availability for phone calls ☐ Morning ☐ Afternoon

Phone number you can be reached at: _____

Can we leave a message on your voicemail ☐ Yes ☐ No

Availability for information sessions ☐ Morning ☐ Afternoon ☐ Evening

Preferred language ☐ French ☐ English ☐ Both

**ALL INFORMATION WILL REMAIN CONFIDENTIAL**

**For administrative use only:** Date received: Initials: