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
- ☐ Fall Prevention

Mental Health

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

Other: _____

Group Information Sessions

- ☐ Stress and Anxiety Management
- ☐ Sleep Management
- ☐ Managing Anxiety in Children
- ☐ Feminine Health (On the way to menopause!)
- ☐ Lifestyle Medicine
- ☐ Motivation and Energy

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: