

Date: _____

Name: _____

Date of birth: _____



CLARENCE-ROCKLAND
FAMILY HEALTH TEAM

Questionnaire for Interdisciplinary Services

Please indicate the primary reason for seeking our services:

Nutrition

- ☐ Weight Management
- ☐ Diabetes
- ☐ Digestion Issues
- ☐ Nutrition in children
- ☐ Nutrition in elderly
- ☐ Other: _____

Physical Activity & Exercise

- ☐ Joint Pain
- ☐ Weight Management
- ☐ Chronic Disease Management
- ☐ Physical Conditioning
- ☐ Fall Prevention
- ☐ Other: _____

Mental Health

- ☐ Anxiety / Stress
- ☐ Depression
- ☐ Addiction
- ☐ Grief
- ☐ Trauma: _____
- ☐ Forms / documents
- ☐ Other: _____

Group Information Sessions (# of sessions)

- | | | |
|--|--|--|
| ☐ Stress and Anxiety Management (1) | ☐ Sleep Management (1) | ☐ Initiation of a GLP-1 (1) |
| ☐ Managing Anxiety in Children (1) | ☐ Menopause (3) | |
| ☐ Lifestyle Medicine (6-7) | ☐ Motivation and Energy (1) | |

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: