Lynda Rees

Please complete the following questions. There are no right or wrong answers. If you are unsure about how to answer a question, please give your best answer.

Name:_____

Phone: Home/Cell/Business: _____

Email:_____Website:_____

Address:_____

Date of Birth: _____

Occupation: _____

Employer: _____

Partner/Spouse's Name: _____

Number of years together: _____

Were there previous marriages/committed relationships for either spouse/partner? _____

Name(s) of children/half/step	Date of Birth	School
1.		
2.		
3.		
4.		

Were you referred by anyone? Yes No

If yes, by whom? _____

Reasons for your referral:_____

Name of Family Physician: _____ Telephone:_____

Address: _____

Are you receiving or have received help from a medical doctor/ specialist, alternative health practitioner, therapist, coach or program? Yes No

If yes, what is their name, specialty, date and reason

_____
_____
_____
_____
_____

Please list your present symptoms and/or concerns:

_____
_____
_____
_____
_____

What illnesses/accidents have you had? If so, please list and when this illness first appeared.

_____
_____
_____
_____

What surgeries/treatments have you had (Medical or Alternative/Complementary)? If so, please list with dates.

_____
_____
_____

Please list any medications your are on (prescription and non prescription).

_____
_____
_____

List illnesses each of your parents, grandparents and siblings had/have:

_____
_____
_____

What are the major life events you believe have impacted you?

What is the quality of your sleep and how many hours do you sleep?

What exercise do you do and how regular are you?

Would you consider yourself to be a healthy eater and what types of food do you eat?

What do you expect from our work together

Please list everyone with whom you presently live:

Signature: _____Date:_____

Thank you for taking the time to complete this form. I look forward to working with you.

Lynda Rees RN, Psychotherapist, RMFT, CCFT, M.Sc.