Lifestyle Health Assessment Form2

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|  | **GETTING STARTED**  |  |
|  | **Very poor health**  | **Excellent health**  |
| a. | Please circle your current overall **LEVEL OF HEALTH**. 0 1 2 3 4 5 6 7 8 9 10  |
| b. | Please rank the top **3 areas** you would like to improve with 1 being the most important and 3 the least important.Sleep Weight Management Exercise Purpose & Connection Substance Use  |    |  | NutritionMental Health |
|  |  | **Not important at all**  |  |  |  | **Very important**  |
| c.d.e.f.g.h. | How **IMPORTANT** is it for you to make the change you ranked as the **#1** most motivated topic area to address?How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#1** most motivated topic area to address?How **IMPORTANT** is it for you to make the change you ranked as the **#2** most motivated topic area to address?How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#2** most motivated topic area to address?How **IMPORTANT** is it for you to make the change you ranked as the **#3** most motivated topic area to address?How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#3** most motivated topic area to address? | 0 0 0 0 0 0  | 111111 |  2  2  2  2  2  2  | 3 43 43 43 43 43 4 | 5 5 5 5 5 5  | 6 7 8 9 10 6 7 8 9 10 6 7 8 9 10 6 7 8 9 10 6 7 8 9 10 6 7 8 9 10  |
| i. | **What would you like to gain from this lifestyle visit?** *Check all that apply* More medical/scientific knowledge Practical health tips  Accountability Personalized plan  |  |  Other:  |

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| **SLEEP**  |  |  |  |  |  |
| **Please answer based on your sleeping patterns OVER the LAST TWO WEEKS**  | **Never** | **Seldom** | **Sometimes** | **Often** | **Always** |
| a. How often have you had difficulty staying awake during routine tasks? | 1  | 2  | 3  | 4  | 5  |
| b. How often have you had difficulty staying awake while driving? | 1  | 2  | 3  | 4  | 5  |
| c. How often have you felt fatigued or needed to nap during the day? | 1  | 2  | 3  | 4  | 5  |
| d. How often has it taken you more than 30 minutes to fall asleep at night? | 1  | 2  | 3  | 4  | 5  |
| e. How often have you woken up at night? | 1  | 2  | 3  | 4  | 5  |
| f. How often have you unintentionally woken up early in the morning? | 1  | 2  | 3  | 4  | 5  |
| g. How often do you look at a screen within 2 hours of sleeping (i.e. TV, computer, iPad, or Phone)?  | 1  | 2  | 3  | 4  | 5 |
| h. How often have your legs or arms jerked during sleep? | 1  | 2  | 3  | 4  | 5  |
| i. How often have you experienced “creeping” or “crawling” feelings in your legs? | 1  | 2  | 3  | 4  | 5  |
| j. How often have you snored loudly, gasped, choked, or stopped breathing during sleep? | 1  | 2  | 3  | 4  | 5  |
| k. How often have you used sleeping aids (i.e. tobacco, alcohol, over-the-counter medications, or prescription medications) to help you fall asleep? | 1  | 2  | 3  | 4  | 5  |
| l. Do you have a job that requires night shifts? | 1  | 2  | 3  | 4  | 5  |
| m. Do you have a medical condition or chronic pain that interferes with your sleep? | 1  | 2  | 3  | 4  | 5  |
| n. On an average weekday do you get at least 7-8 hours of sleep in a 24-hour period? | 1  | 2  | 3  | 4  | 5  |
| o. On an average weekend do you get at least 7-8 hours of sleep in a 24-hour period? | 1  | 2  | 3  | 4  | 5  |

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| **NUTRITION**  |
| **EATING PATTERNS** ***Please answer based on your typical eating habits***1. On average, how many cups (8 oz.) of caffeinated beverages do you drink **per day** 0 1 2 3 4+

 (tea, soda, coffee, or energy drinks)? 1. On average, how many servings of alcohol do you drink **per day**? 0 1 2 3 4+
2. On average, how many cups (8 oz.) of sugary drinks (soda, sports drinks, juice) do you 0 1 2 3 4+ drink **per day**?
3. On average, how often do you snack on convenience or “junk” food **per day**? 0 1 2 3 4+

(i.e. chips, candy, granola bars, crackers, cookies, etc.) 1. On average, how many meals do you buy from a restaurant or fast food **per week**? 0 1 2 3 4+
2. On average, do you drink at least 8 glasses of water **per day**? No Yes
3. On average, do you eat at least 5 handfuls of nuts **per week**? No Yes
4. Do you use natural or artificial sweeteners? No Yes

(i.e. Equal, Stevia, Splenda, Sweet & Low, honey, agave, etc.)1. Do you add salt to most of your meals? No Yes
2. Do you eat processed meats (i.e. sausage, hot dogs, salami, bacon)? No Yes
3. Do you have any bad reactions (sensitivities or allergies) to food? If yes, please list here: l.

Do you avoid any particular foods? If yes, please list here:m.Do you have foods that you crave? If yes, please list here:Are you currently following a particular diet or nutrition plan? If yes, please list here:During the last 3 months, did you have any episodes of excessive overeating? If yes please explain here:Are you concerned about making the wrong food choices? If yes, please explain here:Have you ever had an eating disorder? If yes, please list here:n.o.p.q. |
| **Do you use any of the following VITAMINS or SUPPLEMENTS? *Check all that apply***  | **Do you use any of the following OILS with your meals or cooking? *Check all that apply***  |
|  ❏ Vitamin D ❏ Calcium ❏ Vitamin B12 |  ❏ Olive Oil ❏ Canola Oil ❏ Vegetable Oil |
|  ❏ Probiotics ❏ Omega 3 ❏ Multivitamin |  ❏ Coconut Oil ❏ Butter ❏ Lard |
| Other:  | Other:  |
| **FOOD RECALL: *Please record below what AND how much you ate and drank yesterday (or the last typical day)*** Breakfast:  Time: Lunch:  Time: Dinner:  Time: Snacks:  Time: Drinks/Beverages:  Time:  |

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| **WEIGHT MANAGEMENT**  |
| **BEHAVIOR PATTERNS** **Never****Seldom****Sometimes****Often****Always**1. How often do you skip meals? 1 2 3 4 5
2. How often do you snack in between meals? 1 2 3 4 5
3. How often do you eat while watching TV? 1 2 3 4 5
4. How often do you eat while in bed? 1 2 3 4 5
5. How often do you have difficulty sleeping? 1 2 3 4 5
6. How often do you lack physical activity or exercise? 1 2 3 4 5
7. How often do you feel a lack of purpose or meaning in your life? 1 2 3 4 5
 |
| **Which of the following factors apply to your eating habits and current lifestyle? *Check all that apply*** ❏ Like healthy food ❏ Don’t like healthy food ❏ Know how to cook healthy foods❏ Fast eater ❏ Eat slowly ❏ Read nutrition labels❏ Rely on packaged or fast foods ❏ Dislike cooking ❏ Prepare meals at home❏ Do not plan meals ❏ Eat a variety of foods ❏ Always hungry❏ Late night eater ❏ Negative relationship to food ❏ Erratic eater❏ No time to prepare healthy food ❏ Don’t know how to cook ❏ Live alone or eat alone often choices |
| **Do any of the following situations or emotions cause you to eat? *Check all that apply*** ❏ Sadness ❏ Pain ❏ Insomnia ❏ Anxiety❏ Fatigue ❏ Social or Family Situations ❏ Boredom ❏ Stress |

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| **WEIGHT MANAGEMENT (continued)**  |
| **WEIGHT HISTORY**  a. Have you ever been overweight or obese? If yes, answer below: No Yes Were you overweight as a child? No Yes Were you overweight as a teenager? No Yes  Were you overweight between the ages of 20-29? No Yes  Were you overweight between the ages of 30-39? No Yes Were you overweight above the age of 40? No Yes b. Are you currently trying to lose or gain weight? No Yes If yes, please circle your goal: Lose weight Gain weight  c. Have you ever intentionally lost or reduced your weight by more than 5 lbs.? No Yes If yes, did you regain weight within 1 year? No Yes d. Have you had weight loss surgery? No Yes If yes, please list the type of surgery you had:  |
| **Have you ever used weight loss medications? *If yes, circle which ones you have used? If other, please list.***  ❏ Acutrim ❏ Alli ❏ Amphetamines ❏ Anorex ❏ Belviq ❏ Byetta ❏ Contrave ❏ Dexatrim ❏ Didrex ❏ Fastin ❏ Fenfluramine ❏ Mazanor ❏ Meridia ❏ Obalan ❏ Phendiet ❏ Fen-Phen ❏ Phentermine ❏ Plegine ❏ Plegine ❏ Prozac ❏ Pondimin ❏ Qsymia ❏ Redux ❏ Sanorex ❏ Tenuate ❏ Tepanol ❏ Vyvanse ❏ Wechless❏ Wellbutrin ❏ Xenical ❏ I don't remember the name of the medication ❏ Other  |
| **WEIGHT LOSS STATEGIES** **Have you tried any of the following alternative therapies or programs? *Check all that apply. If other, please list.*** ❏ Other❏Acupuncture❏Acupressure❏Nutritionist/Registered Dietitian❏Residential Programs❏Hypnosis❏Physical Activity/Exercises |
| **Which commercial or fad diets have you tried in the past? *Check all that apply. If other, please list.***  ❏ Atkins Diet ❏ Low Fat ❏ Calorie Counting ❏ Paleo ❏ CHIP ❏ Vegan ❏ Mediterranean Diet ❏ Elimination Diet (Allergy) ❏ Gluten Free ❏ Vegetarian ❏ Jenny Craig ❏ Weight Watchers ❏ Low Carb ❏ Other  |

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| **EXERCISE**  |
| **EXERCISE HABITS: AEROBIC/CARDIO TRAINING** 1. During the average week, how many **days** do you exercise at a moderate to strenuous intensity (i.e. brisk walking or enough to break a light sweat)? days
2. During an average session, how many **minutes** do you exercise at a moderate to strenuous intensity (i.e. brisk

walking or enough movement to break a light sweat)? min c. total min/week (days x min) List types of aerobic activities you do (i.e. walking, jogging, swimming, bicycling, dancing, etc.): |
| **EXERCISE HABITS: STRENGTH/RESISTANCE TRAINING** 1. During the average week, how many **days** do you do strength/resistance training? days
2. How many **minutes** do you exercise with strength/resistance training? min

 total min/week (days x min) 1. List types of activities you do (i.e. weightlifting, Pilates, kettle ball, resistance machines, exercise bands, etc.):
 |
| **What MOTIVATES you *or would motivate you* to exercise?** *Check top three*  ❏ Nothing would motivate me ❏ Family or partner ❏ Improve mood ❏ Weight reduction ❏ Control Blood glucose ❏ Body Image ❏ Increase Energy Reduce blood pressure❏ ❏ Decrease stress ❏ Prevent heart disease ❏ Prevent Bone loss Improve sleep❏ ❏ Increase self-esteem ❏ Other: |
| **Are there any BARRIERS or PROBLEMS that limit exercise?** *Check all that apply*  ❏ No barriers ❏ Depression ❏ Work Responsibility ❏ Cost ❏ Life Transition Period ❏ Time ❏ Fear ❏ Other ❏ Family Responsibility ❏ Apparel ❏ Energy |
| **EXERCISE SAFETY** 1. Do you have any injuries that would make it difficult to exercise? No Yes

If yes, please explain: 1. Do you have any joint, muscle, or bone problems that might get worse with exercise? No Yes

If yes, please explain: 1. Do you have any breathing problems while exercising? No Yes

If yes, please explain: 1. Do you have any balance problems or have had a fall in the last 6 months? No Yes

If yes, please explain: 1. Do you have any difficulty completing your activities of daily living (i.e. showering, dressing, toileting)? No Yes If yes, please explain:
 |
| **Do you have any of the following health problems? *Check all that apply***  ❏ Arrhythmia or irregular heartbeat ❏ Uncontrolled diabetes ❏ Recent heart attack ❏ Arthritis or significant joint pain ❏ Severe or uncontrolled heart ❏ Chronic or unusual fatigue/tirednessfailure ❏ Chest pain/angina ❏ Difficulty breathing with activity❏ Uncontrolled asthma❏ Other |
| **MENTAL HEALTH**  |  |  |
| **PERCEIVED STRESS**  | **Never****Seldom****Sometimes****Often** | **Always** |
|  a. How often have you felt that you were unable to control the important things in your life? |  1 2 3 4  | 5  |
| b. How often have you felt **lack of** confidence about your ability to handle your personal problems? |  1 2 3 4  | 5  |
|  c. How often have you felt that things were **not** going your way? |  1 2 3 4  | 5  |
|  d. Have often have you found it hard to let go of things that upset you? |  1 2 3 4  | 5  |
| **How do you COPE with stress**❏ Meditation | **? *Check all that apply*** ❏ Food (too much, too little)  | ❏ Gambling | ❏ Distraction |  |
| ❏ Exercise/Physical Activity | ❏ Spirituality/Faith | ❏ Journaling | ❏ Hurting yourself (i.e.cutting, etc.) |  |
| ❏ Counseling/Psychotherapy  | ❏ Sex | ❏ Massage/Body work | ❏ Pet therapy |  |  |  |
| ❏ Socializing with friends or family | ❏ Recreational drugs (i.e.marijuana, cocaine, etc.) | ❏ Prayer | ❏ Other |  |  |  |  |
| ❏ Art | ❏ Television and/or video games | ❏ Substance (tobacco, alcohol) |  |  |  |  |  |
| **RESILIENCE** **When I am under extreme stre** | **ss**  |  | **Never** | **Seldom** | **Sometimes** | **Often** | **Always** |
|  a. I find a way to learn from my experience. |  | 1  | 2  | 3  | 4  | 5  |
|  b. I find a way to take action. |  | 1  | 2  | 3  | 4  | 5  |
|  c. I find it easy to prioritize what is important in my life. |  | 1  | 2  | 3  | 4  | 5  |
|  d. I look at a stressful situation as an opportunity to grow. |  | 1  | 2  | 3  | 4  | 5  |
|  e. I meet the goals I set for myself. |  | 1  | 2  | 3  | 4  | 5  |
|  f. I believe that there are a lot of ways around a problem. |  | 1  | 2  | 3  | 4  | 5  |
|  g. I feel motivated to pursue my goals. |  | 1  | 2  | 3  | 4  | 5  |
|  h. I know I can get through it. |  1 2 3 4  | 5  |

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| **MENTAL HEALTH (continued)**  |  |  |  |  |  |
| **MIND-BODY CONNECTION**  | **Never** | **Seldom** | **Sometimes** | **Often** | **Always** |
| a. I meet the goals I set for myself. | 1  | 2  | 3  | 4  | 5  |
| b. Do thoughts or feelings affect your physical health? | 1  | 2  | 3  | 4  | 5  |
| c. Could you be experiencing some emotion and not be aware of it? | 1  | 2  | 3  | 4  | 5  |
| d. Are you aware of tension in your body? | 1  | 2  | 3  | 4  | 5  |
| e. Do you notice how your body changes when angry? | 1  | 2  | 3  | 4  | 5  |
| f. Do you notice stress in your body? | 1  | 2  | 3  | 4  | 5  |
| g. Do you notice how your body reacts to emotions? | 1  | 2  | 3  | 4  | 5  |
| **DEPRESSION** **Over the last 2 weeks, how often have you been bothered by the following?**  |  | **Not at all** | **Several days** | **Most days** | **Daily**  |
| a. Little interest or pleasure in doing things. |  | 0  | 1  | 2  | 3  |
| b. Feeling down, depressed or hopeless. |  | 0  | 1  | 2  | 3  |
| c. Trouble falling asleep, staying asleep, or sleeping too much. |  | 0  | 1  | 2  | 3  |
| d. Feeling tired or having little energy. |  | 0  | 1  | 2  | 3  |
| e. Poor appetite or overeating. |  | 0  | 1  | 2  | 3  |
| f. Feeling bad about yourself or that you’re a failure or have let yourself or your family down. |  | 0  | 1  | 2  | 3  |
| g. Trouble concentrating on things, such as reading the newspaper or watching television. |  | 0  | 1  | 2  | 3  |
| h. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.  |  | 0  | 1  | 2  | 3  |
| i. Thoughts that you would be better off dead or of hurting yourself in some way. |  | 0  | 1  | 2  | 3  |
| **ANXIETY** **Over the last 2 weeks, how often have you been bothered by the following?**  |  | **Not at all** | **Several days** | **Most days** | **Daily**  |
| a. Feeling nervous, anxious, or on edge. |  | 0  | 1  | 2  | 3  |
| b. Not being able to stop or control worrying. |  | 0  | 1  | 2  | 3  |
| c. Worrying too much about different things. |  | 0  | 1  | 2  | 3  |
| d. Trouble relaxing. |  | 0  | 1  | 2  | 3  |
| e. Being so restless that it’s hard to sit still. |  | 0  | 1  | 2  | 3  |
| f. Becoming easily annoyed or irritable. |  | 0  | 1  | 2  | 3  |

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| **PURPOSE AND CONNECTION**  |  |  |  |  |  |
| How often do you agree with the following:  | **Never** | **Seldom** | **Sometimes** | **Often** | **Always** |
| a. I live a purposeful and meaningful life | 1  | 2  | 3  | 4  | 5  |
| b. I have a spiritual community that I can turn to in times of need | 1  | 2  | 3  | 4  | 5  |
| c. I have a source of inner strength and meaning | 1  | 2  | 3  | 4  | 5  |
| d. I am satisfied with my current belief system | 1  | 2  | 3  | 4  | 5  |
| e. I have people who care about what happens to me | 1  | 2  | 3  | 4  | 5  |
| f. I have people who accept me at my worst and best | 1  | 2  | 3  | 4  | 5  |
| g. I have people I trust at home or work who I can talk to about my problems | 1  | 2  | 3  | 4  | 5  |
| h. I get help when I’m sick | 1  | 2  | 3  | 4  | 5  |
| **SMOKING AND SUBSTANCE HISTORY**  |
| **NICOTINE/TOBACCO** (i.e. cigarettes, e-cigarettes, e-cigarettes/vaping, cigars, chew, snuff) 1. Do you use any of the nicotine products listed above? No Yes If yes, do you want to quit using the nicotine/tobacco products? No Yes

If yes, answer the questions below:1. How soon after you wake up do you use nicotine/tobacco?

❏ After 60 minutes ❏ 31-60 minutes ❏ 6-30 minutes ❏ Within 5 minutes c. How many cigarettes do you smoke per day? ❏ 10 or less ❏ 11-20 ❏ 21-30 ❏ 31+ |
| d. What age did you start smoking?  | h. How many times have you seriously tried to quit?  |
| e. What is the longest time period you have stayed quit? | i. For your most recent quit attempt, how long did it last? |
| f. What made you start smoking again?  | j. Who is supporting you to quit smoking? |
| g. Which of the following people smoke around you? *Check all that apply* ❏ Friends ❏ Family ❏ Partner ❏ Co-Workers ❏ Other:  | k. What is your most important reason to quit smoking? |
| 1. Are you currently using or have used any medications to help you quit smoking? No Yes

If yes, check with of the following medications you have used: ❏ Nicotine Patch ❏ Nicotine Gum ❏ Nicotine Lozenge ❏ Wellbutrin/Bupropion Pill ❏ Chantix/ Varenicline Pill ❏ Other: 1. If you used any of the medication listed above, did they help? No Yes

If yes, list which ones helped:  |

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|  | **SMOKING AND SUBSTANCE (continued)**  |  |
| n. Have you used any methods in the past other than medications to try to quit? No Yes If yes, check which of the following methods you have used:❏ Self-help ❏ Gradual reduction ❏ Cold turkey ❏ Hypnosis ❏ Acupuncture ❏ Special filters ❏ Vaping/e-cigarettes ❏ Other:  |
| **ALCOHOL** 1. Do you drink alcohol? No Yes

If yes, please answer the questions below:1. What type of alcohol do you prefer?
2. On average, how many servings do you drink per day/week/month/year on average?

If yes, please answer the questions below:1. Have you ever felt you should “**Cut** down” on your drinking? No Yes
2. Have people **Annoyed** you by criticizing your drinking? No Yes
3. Have you ever felt **Guilty** about your drinking? No Yes
4. Have you ever had a drink in the morning to steady your nerves or to get rid of a handover No Yes (**eye opener**)?
5. Do you binge drink (more than 5 drinks for men or 4 drinks for women within 2 hours)? No Yes
 |
| **Have you used any of the following substances in the past year?**  **Recreational drugs** (cocaine, heroin, meth, etc.)  |  |  | No Yes  |
| If yes, what level of concern do you have regarding use of the substances  | **No Concern**  |  | **High Concern**  |
|  | 0  | 1  | 2 3 4 5  |
|  If yes, how much substance do you usually use? **Marijuana**   |  |  | No Yes  |
| If yes, what level of concern do you have regarding use of the substances  | **No Concern**  |  | **High Concern**  |
| If yes, how much substance do you usually use?  | 0  | 1  | 2 3 4 5  |
| **TREATMENT HISTORY** Have you ever received treatment for a mental health problem?  |  |  |  No Yes  |
|  Have you ever received treatment for drug or alcohol use?  |  |  |  No Yes  |

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| **MEDICAL SYMPTOM QUESTIONNAIRE (MSQ)**  |
| This questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the **PAST 30 DAYS**. If you are taking after the first time, record your symptoms for the LAST 48 HOURS ONLY. **Point Scale** 0 = Never or almost never have the symptom 3 = Frequently have it, effect is not severe 1 = Occasionally have it, effect is not severe 4 = Frequently have it, effect is severe 2 = Occasionally have, effect is severe  |
| **DIGESTIVE**   |  |  | **EMOTIONS**  |  |
| Diarrhea  |  0 1 2 3  | 4  | Mood swings  |  0 1 2 3 4  |
| Constipation  |  0 1 2 3  | 4  | Anxiety, fear, nervousness  |  0 1 2 3 4  |
| Bloated feeling  |  0 1 2 3  | 4  | Anger, irritability, aggressiveness  |  0 1 2 3 4  |
| Belching, passing gas  |  0 1 2 3  | 4  | Depression  |  0 1 2 3 4  |
| Heartburn Intestinal/stomach pain  |  0 1 2 3  0 1 2 3  | 4 4  |  | **Total points**  |
| **ENERGY/ACTIVITY**  |  |
| Nausea or vomiting  |  0 1 2 3  | 4  | Fatigue, sluggishness  |  0 1 2 3 4  |
|  | **Total points**  |  | Apathy, lethargy Hyperactivity  |  0 1 2 3 4  0 1 2 3 4  |
| **EARS**  |  |  |
| Itchy ears  |  0 0 1 2  | 3  | Restlessness  |  0 1 2 3 4  |
| Earaches, ear infections Drainage from ear  |  0 1 2 3  0 1 2 3  | 4 4  |  | **Total points**  |
| **EYES**  |  |
| Ringing in ears, hearing loss  |  0 1 2 3  | 4  | Watery or itchy eyes  |  0 1 2 3 4  |
|  | **Total points**  |  | Swollen, reddened or sticky eyelids Bags or dark circles under eyes  |  0 1 2 3 4  0 1 2 3 4  |
| **HEAD**  |  |  |
| Headaches Faintness or lightheadedness  |  0 1 2 3  0 1 2 3  | 4 4  | Blurred or tunnel vision *(does not include near or far sightedness)*  |  0 1 2 3 4  |
| Dizziness Insomnia  |  0 1 2 3  0 1 2 3  | 4 4  |  | **Total points**  |
| **NOSE**  |  |
|  | **Total points**  |  | Stuffy nose Sinus problems  |  0 1 2 3 4  0 1 2 3 4  |
| **HEART**  |  |  |
| Irregular or skipped heartbeat  |  0 1 2 3  | 4  | Sneezing attacks  |  0 1 2 3 4  |
| Chest pain  |  0 1 2 3  | 4  | Excessive mucous formation  |  0 1 2 3 4  |
| Rapid or pounding heartbeat  |  0 1 2 3  | 4  | Hay fever  |  0 1 2 3 4  |
|  | **Total points**  |  |  | **Total points**  |
| **JOINTS/MUSCLES**  |  |  | **SKIN**  |  |
| Pains or aches in joints  |  0 1 2 3  | 4  | Acne  |  0 1 2 3 4  |
| Arthritis  |  0 1 2 3  | 4  | Hives, rashes, dry skin  |  0 1 2 3 4  |
| Stiffness or limitations of movement  |  0 1 2 3  | 4  | Hair loss  |  0 1 2 3 4  |
| Pain or aches in muscles  |  0 1 2 3  | 4  | Flushing or hot flushes  |  0 1 2 3 4  |
| Feeling of weakness or tiredness  |  0 1 2 3  | 4  | Excessive sweating  |  0 1 2 3 4  |
|  | **Total points**  |  |  | **Total points**  |
| **LUNGS**  |  |  | **WEIGHT**  |  |
| Chest congestion  |  0 1 2 3  | 4  | Binge eating/drinking  |  0 1 2 3 4  |
| Asthma, bronchitis  |  0 1 2 3  | 4  | Craving certain foods  |  0 1 2 3 4  |
| Shortness of breath  |  0 1 2 3  | 4  | Excessive weight  |  0 1 2 3 4  |
| Difficulty breathing  |  0 1 2 3  | 4  | Water retention  |  0 1 2 3 4  |
|  | **Total points**  |  | Underweight Compulsive eating  |  0 1 2 3 4  0 1 2 3 4  |
| **MIND**  |  |  |
| Poor memory Confusion, poor comprehension  |  0 1 2 3  0 1 2 3  | 4 4  |  | **Total points**  |
| **OTHER**  |  |
| Poor concentration  |  0 1 2 3  | 4  | Frequent illness  |  0 1 2 3 4  |
| Poor physical coordination  |  0 1 2 3  | 4  | Frequent or urgent urination  |  0 1 2 3 4  |
| Difficulty making decisions  |  0 1 2 3  | 4  | Genital itch or discharge  |  0 1 2 3 4  |
| Stuttering or stammering Learning disabilities  |  0 1 2 3  0 1 2 3  | 4 4  |  | **Total points**  |
|  |
| Slurred speech  |  0 1 2 3 **Total points**  | 4  | **GRAND TOTAL**  |
| **KEY:** Add individual scores and total each group. Add each group score to give a grand total. \*Optimal is <10; Mild Symptoms: 10-50; Moderate Symptoms: 50-100; Severe Symptoms: over 100 |

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| --- | --- | --- | --- | --- |
|  | **PREVENTIVE SERVICES**  |  |  |  |
| a. | Have you had a physical exam and/or “Wellness” Visit in the past 12 months? If yes, list date and outcome:  | No  | Yes  | I don't know  |
| b. | Have you had a dental exam and teeth cleaning in the past 12 months? If yes, list date and outcome:  | No  | Yes  | I don't know  |
| c. | Have you been screened for diabetes with blood work? If yes, list date and outcome:  | No  | Yes  | I don't know  |
| d. | Have you had your cholesterol, lipids or triglycerides measured? If yes, list date and outcome:  | No  | Yes  | I don't know  |
| e. | Have you ever had a bone density test to check for osteoporosis? If yes, list date and outcome:  | No  | Yes  | I don't know  |
| f. | Do you have any balance problems or have had a fall in the last 6 months? If yes, list date and outcome:  | No  | Yes  | I don't know  |
| g. | Do you have any difficulty completing your activities of daily living (i.e. showering, dressing, toileting)?If yes, list date and outcome:  | No  | Yes  | I don't know  |
| h. | Do you have any concerns about your ability to drive safely or have you had any car accidents in the past 12 months?If yes, list date and outcome:  | No  | Yes  | I don't know  |
| i. | Do you have any concerns about your memory? If yes, list date and outcome:  | No  | Yes  | I don't know  |
| j. | Do you have any trouble with your hearing? If yes, list date and outcome:  | No  | Yes  | I don't know  |
| k. | Have you had your eyes checked for vision problems? If yes, list date and outcome:  | No  | Yes  | I don't know  |
| l. | Have you ever had your metabolism or thyroid checked? If yes, list date and outcome:  | No  | Yes  | I don't know  |
| m. | Have you ever been told that you have a sexually transmitted disease/infection? If yes, list date and outcome:  | No  | Yes  | I don't know  |
| n. | If you smoke, have you ever had an abdominal ultrasound to check for possible aneurysms?If yes, list date and outcome:  | No  | Yes  | I don't know  |
| o. | Have you ever received counseling behavioral therapy for any of the following problems?❏ Weight management ❏ Nutrition ❏ Smoking or use of other ❏ Alcohol use or obesity nicotine products |  |
| p. | Which of the following screenings have you completed❏ Colon cancer screen (stool test ❏ Breast cancer screen ❏ Cervical cancer screen (PAP or colonoscopy (mammogram) smear) ❏ HIV/AIDS blood work screen ❏ Hepatitis C blood work screen ❏ Depression or sadness screen |
| q. | Have you had the following vaccines? ❏ Flu ❏ Hepatitis B ❏ Pneumococcal or Pneumonia |