

# Lifestyle Assessment Long Form

## GETTING STARTED

Please indicate your **CURRENT LEVEL OF HEALTH** - Rate on a scale of 0 as very poor and 10 as excellent

- a. Select your **LEVEL OF HEALTH** by clicking on the drop-down arrow on the blue-shaded box.  
 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 _____	Nutrition _____
Exercise _____	Purpose & Connection _____	Mental Health _____
Substance Use _____		

Rate on a scale of 0 as Not important at all  
and 10 as Very important

- c. How **IMPORTANT** is it for you to make the change you ranked as the **#1** most motivated topic area to address?  
 d. How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#1** most motivated topic area to address?  
 e. How **IMPORTANT** is it for you to make the change you ranked as the **#2** most motivated topic area to address?  
 f. How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#2** most motivated topic area to address?  
 g. How **IMPORTANT** is it for you to make the change you ranked as the **#3** most motivated topic area to address?  
 h. How **CONFIDENT** are you regarding your ability to make the change you ranked as the **#3** most motivated topic area to address?  
 i. **What would you like to gain from this lifestyle visit?** *Check all that apply*

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> More medical/scientific knowledge | <input type="checkbox"/> Practical health tips | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Accountability                    | <input type="checkbox"/> Personalized plan     |                                       |

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## SLEEP

Please answer based on your sleeping patterns OVER the LAST TWO WEEKS

Rate on scale:

Never	Seldom	Sometimes	Often	Always
1	2	3	4	5

- a. How often have you had difficulty staying awake during routine tasks?
- b. How often have you had difficulty staying awake while driving?
- c. How often have you felt fatigued or needed to nap during the day?
- d. How often has it taken you more than 30 minutes to fall asleep at night?
- e. How often have you woken up at night?
- f. How often have you unintentionally woken up early in the morning
- g. How often do you look at a screen within 2 hours of sleeping (i.e. TV, computer, iPad, or Phone)?
- h. How often have your legs or arms jerked during sleep?
- i. How often have you experienced “creeping” or “crawling” feelings in your legs?
- j. How often have you snored loudly, gasped, choked, or stopped breathing during sleep?
- k. How often have you used sleeping aids (i.e. tobacco, alcohol, over-the-counter medications, or prescription medications) to help you fall asleep?
- l. Do you have a job that requires night shifts?
- m. Do you have a medical condition or chronic pain that interferes with your sleep?
- n. On an average weekday do you get at least 7-8 hours of sleep in a 24-hour period?
- o. On an average weekend do you get at least 7-8 hours of sleep in a 24-hour period?

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## NUTRITION

### EATING PATTERNS

*Please answer based on your typical eating habits*

- a. On average, how many cups (8 oz.) of caffeinated beverages do you drink **per day** (tea, soda, coffee, or energy drinks)?
- b. On average, how many servings of alcohol do you drink **per day**?
- c. On average, how many cups (8 oz.) of sugary drinks (soda, sports drinks, juice) do you drink **per day**?
- d. On average, how often do you snack on convenience or "junk" food **per day**? (i.e. chips, candy, granola bars, crackers, cookies, etc.)
- e. On average, how many meals do you buy from a restaurant or fast food **per week**?
- f. On average, do you drink at least 8 glasses of water **per day**?
- g. On average, do you eat at least 5 handfuls of nuts **per week**?
- h. Do you use natural or artificial sweeteners? (i.e. Equal, Stevia, Splenda, Sweet & Low, honey, agave, etc.)
- i. Do you add salt to most of your meals?
- j. Do you eat processed meats (i.e. sausage, hot dogs, salami, bacon)?
- k. 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: \_\_\_\_\_  
\_\_\_\_\_
- n. Are you currently following a particular diet or nutrition plan? If yes, please list here: \_\_\_\_\_  
\_\_\_\_\_
- o. During the last 3 months, did you have any episodes of excessive overeating? If yes please explain here: \_\_\_\_\_  
\_\_\_\_\_
- p. Are you concerned about making the wrong food choices? If yes, please explain here: \_\_\_\_\_  
\_\_\_\_\_
- q. Have you ever had an eating disorder? If yes, please list here: \_\_\_\_\_  
\_\_\_\_\_

#### Do you use any of the following VITAMINS or SUPPLEMENTS? *Check all that apply*

- |                                     |                                  |                                       |
|-------------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Vitamin D  | <input type="checkbox"/> Calcium | <input type="checkbox"/> Vitamin B12  |
| <input type="checkbox"/> Probiotics | <input type="checkbox"/> Omega 3 | <input type="checkbox"/> Multivitamin |
| Other: _____                        |                                  |                                       |

#### Do you use any of the following OILS with your meals or cooking? *Check all that apply*

- |                                      |                                     |  |
|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Olive Oil   | <input type="checkbox"/> Canola Oil | <input type="checkbox"/> Vegetable Oil |
| <input type="checkbox"/> Coconut Oil | <input type="checkbox"/> Butter     | <input type="checkbox"/> Lard          |
| 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: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## WEIGHT MANAGEMENT

### BEHAVIOR PATTERNS

Rate on scale:

Never	Seldom	Sometimes	Often	Always
1	2	3	4	5

- a. How often do you skip meals?
- b. How often do you snack in between meals?
- c. How often do you eat while watching TV?
- d. How often do you eat while in bed?
- e. How often do you have difficulty sleeping?
- f. How often do you lack physical activity or exercise?
- g. How often do you feel a lack of purpose or meaning in your life?

### Which of the following factors apply to your eating habits and current lifestyle? *Check all that apply*

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Like healthy food                       | <input type="checkbox"/> Don't like healthy food       | <input type="checkbox"/> Know how to cook healthy foods |
| <input type="checkbox"/> Fast eater                              | <input type="checkbox"/> Eat slowly                    | <input type="checkbox"/> Read nutrition labels          |
| <input type="checkbox"/> Rely on packaged or fast foods          | <input type="checkbox"/> Dislike cooking               | <input type="checkbox"/> Prepare meals at home          |
| <input type="checkbox"/> Do not plan meals                       | <input type="checkbox"/> Eat a variety of foods        | <input type="checkbox"/> Always hungry                  |
| <input type="checkbox"/> Late night eater                        | <input type="checkbox"/> Negative relationship to food | <input type="checkbox"/> Erratic eater                  |
| <input type="checkbox"/> No time to prepare healthy food choices | <input type="checkbox"/> Don't know how to cook        | <input type="checkbox"/> Live alone or eat alone often  |

### Do any of the following situations or emotions cause you to eat? *Check all that apply*

- |                                  |  |                                   |                                  |
|----------------------------------|--|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Pain                        | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Social or Family Situations | <input type="checkbox"/> Boredom  | <input type="checkbox"/> Stress  |

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## WEIGHT MANAGEMENT (continued)

### WEIGHT HISTORY

- a. Have you ever been overweight or obese? If yes, answer below:  
Were you overweight as a child?  
Were you overweight as a teenager?  
Were you overweight between the ages of 20-29?  
Were you overweight between the ages of 30-39?  
Were you overweight above the age of 40?
- b. Are you currently trying to lose or gain weight?  
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.?  
If yes, did you regain weight within 1 year?
- d. Have you had weight loss surgery?  
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.

- |                                      |                                   |  |                                       |                                  |                                  |                                   |
|--------------------------------------|-----------------------------------|--|---------------------------------------|----------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Acutrim     | <input type="checkbox"/> Alli     | <input type="checkbox"/> Amphetamines                                | <input type="checkbox"/> Anorex       | <input type="checkbox"/> Belviq  | <input type="checkbox"/> Byetta  | <input type="checkbox"/> Contrave |
| <input type="checkbox"/> Dexatrim    | <input type="checkbox"/> Didrex   | <input type="checkbox"/> Fastin                                      | <input type="checkbox"/> Fenfluramine | <input type="checkbox"/> Mazanor | <input type="checkbox"/> Meridia | <input type="checkbox"/> Obalan   |
| <input type="checkbox"/> Phendiet    | <input type="checkbox"/> Fen-Phen | <input type="checkbox"/> Phentermine                                 | <input type="checkbox"/> Plegine      | <input type="checkbox"/> Plegine | <input type="checkbox"/> Prozac  | <input type="checkbox"/> Pondimin |
| <input type="checkbox"/> Qsymia      | <input type="checkbox"/> Redux    | <input type="checkbox"/> Sanorex                                     | <input type="checkbox"/> Tenuate      | <input type="checkbox"/> Tepanol | <input type="checkbox"/> Vyvanse | <input type="checkbox"/> Wechless |
| <input type="checkbox"/> Wellbutrin  | <input type="checkbox"/> Xenical  | <input type="checkbox"/> I don't remember the name of the medication |                                       |                                  |                                  |                                   |
| <input type="checkbox"/> Other _____ |                                   |  |                                       |                                  |                                  |                                   |

### WEIGHT LOSS STRATEGIES

#### Have you tried any of the following alternative therapies or programs? Check all that apply. If other, please list.

- |   |                                      |  |
|---|--------------------------------------|--|
| <input type="checkbox"/> Acupuncture          | <input type="checkbox"/> Acupressure | <input type="checkbox"/> Nutritionist/Registered Dietitian |
| <input type="checkbox"/> Residential Programs | <input type="checkbox"/> Hypnosis    | <input type="checkbox"/> Physical Activity/Exercises       |
| <input type="checkbox"/> Other _____          |                                      |  |

#### Which commercial or fad diets have you tried in the past? Check all that apply. If other, please list.

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Atkins Diet        | <input type="checkbox"/> Low Fat                    | <input type="checkbox"/> Calorie Counting | <input type="checkbox"/> Paleo                      |
| <input type="checkbox"/> CHIP               | <input type="checkbox"/> South Beach                | <input type="checkbox"/> DASH             | <input type="checkbox"/> Vegan                      |
| <input type="checkbox"/> Mediterranean Diet | <input type="checkbox"/> Elimination Diet (Allergy) | <input type="checkbox"/> Gluten Free      | <input type="checkbox"/> Vegetarian                 |
| <input type="checkbox"/> Jenny Craig        | <input type="checkbox"/> Weight Watchers            | <input type="checkbox"/> Low Carb         | <input type="checkbox"/> Slim Fast/Meal Replacement |
| <input type="checkbox"/> Other _____        |   |   |   |

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## EXERCISE

### EXERCISE HABITS: AEROBIC/CARDIO TRAINING

- a. 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
- b. 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  
\_\_\_\_\_ total min/week (days x min)
- c. List types of aerobic activities you do (i.e. walking, jogging, swimming, bicycling, dancing, etc.): \_\_\_\_\_  
\_\_\_\_\_

### EXERCISE HABITS: STRENGTH/RESISTANCE TRAINING

- a. During the average week, how many **days** do you do strength/resistance training? \_\_\_\_\_ days
- b. How many **minutes** do you exercise with strength/resistance training? \_\_\_\_\_ min  
\_\_\_\_\_ total min/week (days x min)
- c. 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

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Nothing would motivate me | <input type="checkbox"/> Family or partner     | <input type="checkbox"/> Improve mood      | <input type="checkbox"/> Weight reduction      |
| <input type="checkbox"/> Control Blood glucose     | <input type="checkbox"/> Body Image            | <input type="checkbox"/> Increase Energy   | <input type="checkbox"/> Reduce blood pressure |
| <input type="checkbox"/> Decrease stress           | <input type="checkbox"/> Prevent heart disease | <input type="checkbox"/> Prevent Bone loss | <input type="checkbox"/> Improve sleep         |
| <input type="checkbox"/> Increase self-esteem      | <input type="checkbox"/> Other: _____          |  |  |

### Are there any **BARRIERS** or **PROBLEMS** that limit exercise? Check all that apply

- |   |                                     |  |                                |
|---|-------------------------------------|--|--------------------------------|
| <input type="checkbox"/> No barriers            | <input type="checkbox"/> Depression | <input type="checkbox"/> Work Responsibility | <input type="checkbox"/> Cost  |
| <input type="checkbox"/> Life Transition Period | <input type="checkbox"/> Time       | <input type="checkbox"/> Fear                | <input type="checkbox"/> Other |
| <input type="checkbox"/> Family Responsibility  | <input type="checkbox"/> Apparel    | <input type="checkbox"/> Energy              |                                |

### EXERCISE SAFETY

- a. Do you have any injuries that would make it difficult to exercise?  
If yes, please explain: \_\_\_\_\_
- b. Do you have any joint, muscle, or bone problems that might get worse with exercise?  
If yes, please explain: \_\_\_\_\_
- c. Do you have any breathing problems while exercising?  
If yes, please explain: \_\_\_\_\_
- d. Do you have any balance problems or have had a fall in the last 6 months?  
If yes, please explain: \_\_\_\_\_
- e. Do you have any difficulty completing your activities of daily living (i.e. showering, dressing, toileting)?  
If yes, please explain: \_\_\_\_\_

### Do you have any of the following health problems? Check all that apply

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Arrhythmia or irregular heartbeat   | <input type="checkbox"/> Uncontrolled diabetes                | <input type="checkbox"/> Recent heart attack                  |
| <input type="checkbox"/> Arthritis or significant joint pain | <input type="checkbox"/> Severe or uncontrolled heart failure | <input type="checkbox"/> Chronic or unusual fatigue/tiredness |
| <input type="checkbox"/> Chest pain/angina                   | <input type="checkbox"/> Uncontrolled asthma                  | <input type="checkbox"/> Difficulty breathing with activity   |
|  |   | <input type="checkbox"/> Other                                |

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## MENTAL HEALTH

### PERCEIVED STRESS

Rate on scale:

Never	Seldom	Sometimes	Often	Always
1	2	3	4	5

- a. How often have you felt that you were unable to control the important things in your life?
- b. How often have you felt **lack of** confidence about your ability to handle your personal problems?
- c. How often have you felt that things were **not** going your way?
- d. How often have you found it hard to let go of things that upset you?

Total:

### How do you COPE with stress? *Check all that apply*

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Meditation                         | <input type="checkbox"/> Food (too much, too little)                        | <input type="checkbox"/> Gambling                     | <input type="checkbox"/> Distraction                           |
| <input type="checkbox"/> Exercise/Physical Activity         | <input type="checkbox"/> Spirituality/Faith                                 | <input type="checkbox"/> Journaling                   | <input type="checkbox"/> Hurting yourself (i.e. cutting, etc.) |
| <input type="checkbox"/> Counseling/Psychotherapy           | <input type="checkbox"/> Sex  | <input type="checkbox"/> Massage/Body work            | <input type="checkbox"/> Pet therapy                           |
| <input type="checkbox"/> Socializing with friends or family | <input type="checkbox"/> Recreational drugs (i.e. marijuana, cocaine, etc.) | <input type="checkbox"/> Prayer                       | <input type="checkbox"/> Other                                 |
| <input type="checkbox"/> Art                                | <input type="checkbox"/> Television and/or video games                      | <input type="checkbox"/> Substance (tobacco, alcohol) |  |

### RESILIENCE

Rate on scale:

Never	Seldom	Sometimes	Often	Always
1	2	3	4	5

#### When I am under extreme stress

- a. I find a way to learn from my experience.
- b. I find a way to take action.
- c. I find it easy to prioritize what is important in my life.
- d. I look at a stressful situation as an opportunity to grow.
- e. I meet the goals I set for myself.
- f. I believe that there are a lot of ways around a problem.
- g. I feel motivated to pursue my goals.
- h. I know I can get through it.

Total:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**MENTAL HEALTH (continued)**

**MIND-BODY CONNECTION**

Rate on scale:   
 Never 1    Seldom 2    Sometimes 3    Often 4    Always 5

- a. I meet the goals I set for myself.
- b. Do thoughts or feelings affect your physical health?
- c. Could you be experiencing some emotion and not be aware of it?
- d. Are you aware of tension in your body?
- e. Do you notice how your body changes when angry?
- f. Do you notice stress in your body?
- g. Do you notice how your body reacts to emotions?

Total:

**DEPRESSION**

Rate on scale:   
 Not at all 0    Several days 1    Most days 2    Daily 3

**Over the last 2 weeks, how often have you been bothered by the following?**

- a. Little interest or pleasure in doing things.
- b. Feeling down, depressed or hopeless.
- c. Trouble falling asleep, staying asleep, or sleeping too much.
- d. Feeling tired or having little energy.
- e. Poor appetite or overeating.
- f. Feeling bad about yourself or that you're a failure or have let yourself or your family down.
- g. Trouble concentrating on things, such as reading the newspaper or watching television.
- 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.
- i. Thoughts that you would be better off dead or of hurting yourself in some way.

Total:

**ANXIETY**

Rate on scale:   
 Not at all 0    Several days 1    Most days 2    Daily 3

**Over the last 2 weeks, how often have you been bothered by the following?**

- a. Feeling nervous, anxious, or on edge.
- b. Not being able to stop or control worrying.
- c. Worrying too much about different things.
- d. Trouble relaxing.
- e. Being so restless that it's hard to sit still.
- f. Becoming easily annoyed or irritable.
- g. Feeling afraid as if something awful might happen.

Total:

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_



## PURPOSE AND CONNECTION

How often do you agree with the following:

Rate on scale:

Never	Seldom	Sometimes	Often	Always
1	2	3	4	5

- a. I live a purposeful and meaningful life
- b. I have a spiritual community that I can turn to in times of need
- c. I have a source of inner strength and meaning
- d. I am satisfied with my current belief system
- e. I have people who care about what happens to me
- f. I have people who accept me at my worst and best
- g. I have people I trust at home or work who I can talk to about my problems
- h. I get help when I'm sick

Total:

## SMOKING AND SUBSTANCE HISTORY

**NICOTINE/TOBACCO** (i.e. cigarettes, e-cigarettes, e-cigarettes/vaping, cigars, chew, snuff)

a. Do you use any of the nicotine products listed above?

If yes, do you want to quit using the nicotine/tobacco products?

If yes, answer the questions below:

b. 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? \_\_\_\_\_

e. What is the longest time period you have stayed quit?  
\_\_\_\_\_

f. What made you start smoking again? \_\_\_\_\_

g. Which of the following people smoke around you?  
*Check all that apply*

Friends                     
  Family                     
  Partner  
 Co-Workers                     
  Other: \_\_\_\_\_

h. How many times have you seriously tried to quit? \_\_\_\_

i. For your most recent quit attempt, how long did it last?  
\_\_\_\_\_

j. Who is supporting you to quit smoking? \_\_\_\_\_

k. What is your most important reason to quit smoking?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

l. Are you currently using or have used any medications to help you quit smoking?

If yes, check with of the following medications you have used:

Nicotine Patch                     
  Nicotine Gum                     
  Nicotine Lozenge  
 Wellbutrin/Bupropion Pill                     
  Chantix/ Varenicline Pill                     
  Other: \_\_\_\_\_

m. If you used any of the medication listed above, did they help?

If yes, list which ones helped: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## SMOKING AND SUBSTANCE (continued)

n. Have you used any methods in the past other than medications to try to quit?

If yes, check which of the following methods you have used:

- |                                      |  |  |                                       |
|--------------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> Self-help   | <input type="checkbox"/> Gradual reduction | <input type="checkbox"/> Cold turkey         | <input type="checkbox"/> Hypnosis     |
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Special filters   | <input type="checkbox"/> Vaping/e-cigarettes | <input type="checkbox"/> Other: _____ |

### ALCOHOL

a. Do you drink alcohol?

If yes, please answer the questions below:

b. What type of alcohol do you prefer? \_\_\_\_\_

c. On average, how many servings do you drink per day/week/month/year on average? \_\_\_\_\_

If yes, please answer the questions below:

d. Have you ever felt you should “**Cut** down” on your drinking?

e. Have people **Annoyed** you by criticizing your drinking?

f. Have you ever felt **Guilty** about your drinking?

g. Have you ever had a drink in the morning to steady your nerves or to get rid of a handover (**eye opener**)?

h. Do you binge drink (more than 5 drinks for men or 4 drinks for women within 2 hours)?

### Have you used any of the following substances in the past year?

#### Recreational drugs (cocaine, heroin, meth, etc.)

If yes, what level of concern do you have regarding use of the substances

<b>No</b>	= 0	5 =	<b>High</b>
<b>Concern</b>			<b>Concern</b>

If yes, how much substance do you usually use? \_\_\_\_\_

#### Marijuana

If yes, what level of concern do you have regarding use of the substances

<b>No</b>	= 0	5 =	<b>High</b>
<b>Concern</b>			<b>Concern</b>

If yes, how much substance do you usually use? \_\_\_\_\_

### TREATMENT HISTORY

Have you ever received treatment for a mental health problem?

Have you ever received treatment for drug or alcohol use?

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## 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  
 1 = Occasionally have it, effect is not severe  
 2 = Occasionally have, effect is severe

3 = Frequently have it, effect is not severe  
 4 = Frequently have it, effect is severe

<p><b>DIGESTIVE</b></p> <p>Diarrhea                      Constipation                      Bloating feeling                      Belching, passing gas                      Heartburn                      Intestinal/stomach pain                      Nausea or vomiting</p> <p style="text-align: right;"><b>Total points _____</b></p>	<p><b>EMOTIONS</b></p> <p>Mood swings                      Anxiety, fear, nervousness                      Anger, irritability, aggressiveness                      Depression</p> <p style="text-align: right;"><b>Total points _____</b></p>
<p><b>EARS</b></p> <p>Itchy ears                      Earaches, ear infections                      Drainage from ear                      Ringing in ears, hearing loss</p> <p style="text-align: right;"><b>Total points _____</b></p>	<p><b>ENERGY/ACTIVITY</b></p> <p>Fatigue, sluggishness                      Apathy, lethargy                      Hyperactivity                      Restlessness</p> <p style="text-align: right;"><b>Total points _____</b></p>
<p><b>HEAD</b></p> <p>Headaches                      Faintness or lightheadedness                      Dizziness                      Insomnia</p> <p style="text-align: right;"><b>Total points _____</b></p>	<p><b>EYES</b></p> <p>Watery or itchy eyes                      Swollen, reddened or sticky eyelids                      Bags or dark circles under eyes                      Blurred or tunnel vision (<i>does not include near or far sightedness</i>)</p> <p style="text-align: right;"><b>Total points _____</b></p>
<p><b>HEART</b></p> <p>Irregular or skipped heartbeat                      Chest pain                      Rapid or pounding heartbeat</p> <p style="text-align: right;"><b>Total points _____</b></p>	<p><b>NOSE</b></p> <p>Stuffy nose                      Sinus problems                      Sneezing attacks                      Excessive mucous formation                      Hay fever</p> <p style="text-align: right;"><b>Total points _____</b></p>
<p><b>JOINTS/MUSCLES</b></p> <p>Pains or aches in joints                      Arthritis                      Stiffness or limitations of movement                      Pain or aches in muscles                      Feeling of weakness or tiredness</p> <p style="text-align: right;"><b>Total points _____</b></p>	<p><b>SKIN</b></p> <p>Acne                      Hives, rashes, dry skin                      Hair loss                      Flushing or hot flushes                      Excessive sweating</p> <p style="text-align: right;"><b>Total points _____</b></p>
<p><b>LUNGS</b></p> <p>Chest congestion                      Asthma, bronchitis                      Shortness of breath                      Difficulty breathing</p> <p style="text-align: right;"><b>Total points _____</b></p>	<p><b>WEIGHT</b></p> <p>Binge eating/drinking                      Craving certain foods                      Excessive weight                      Water retention                      Underweight                      Compulsive eating</p> <p style="text-align: right;"><b>Total points _____</b></p>
<p><b>MIND</b></p> <p>Poor memory                      Confusion, poor comprehension                      Poor concentration                      Poor physical coordination                      Difficulty making decisions                      Stuttering or stammering                      Learning disabilities                      Slurred speech</p> <p style="text-align: right;"><b>Total points _____</b></p>	<p><b>OTHER</b></p> <p>Frequent illness                      Frequent or urgent urination                      Genital itch or discharge</p> <p style="text-align: right;"><b>Total points _____</b></p>
<b>GRAND TOTAL _____</b>	

**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

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## PREVENTIVE SERVICES

- a. Have you had a physical exam and/or "Wellness" Visit in the past 12 months?  
If yes, list date and outcome: \_\_\_\_\_
- b. Have you had a dental exam and teeth cleaning in the past 12 months?  
If yes, list date and outcome: \_\_\_\_\_
- c. Have you been screened for diabetes with blood work?  
If yes, list date and outcome: \_\_\_\_\_
- d. Have you had your cholesterol, lipids or triglycerides measured?  
If yes, list date and outcome: \_\_\_\_\_
- e. Have you ever had a bone density test to check for osteoporosis?  
If yes, list date and outcome: \_\_\_\_\_
- f. Do you have any balance problems or have had a fall in the last 6 months?  
If yes, list date and outcome: \_\_\_\_\_
- g. Do you have any difficulty completing your activities of daily living (i.e. showering, dressing, toileting)?  
If yes, list date and outcome: \_\_\_\_\_
- 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: \_\_\_\_\_
- i. Do you have any concerns about your memory?  
If yes, list date and outcome: \_\_\_\_\_
- j. Do you have any trouble with your hearing?  
If yes, list date and outcome: \_\_\_\_\_
- k. Have you had your eyes checked for vision problems?  
If yes, list date and outcome: \_\_\_\_\_
- l. Have you ever had your metabolism or thyroid checked?  
If yes, list date and outcome: \_\_\_\_\_
- m. Have you ever been told that you have a sexually transmitted disease/infection?  
If yes, list date and outcome: \_\_\_\_\_
- n. If you smoke, have you ever had an abdominal ultrasound to check for possible aneurysms?  
If yes, list date and outcome: \_\_\_\_\_
- o. Have you ever received counseling behavioral therapy for any of the following problems?  
 Weight management or obesity       Nutrition       Smoking or use of other nicotine products       Alcohol use
- p. Which of the following screenings have you completed  
 Colon cancer screen (stool test or colonoscopy)       Breast cancer screen (mammogram)       Cervical cancer screen (PAP 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

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_