Health Review Self-Report Worksheet

Name: _____ **Birthdate:** _____ **Date :** _____

Physical and emotional health have an impact on each other. Information on your physical health will assist with planning your services.

Primary Care Physician/Provider Name: _____ ☐ **NONE**					
Last Seen:	☐ within the past 3 months	☐ within the past 6 months	☐ within the past 1 year	☐ within the past 2 years	☐ greater than 2 years

Dentist Name: _____ ☐ **NONE**					
Last Seen:	☐ within the past 3 months	☐ within the past 6 months	☐ within the past 1 year	☐ within the past 2 years	☐ greater than 2 years

Eye Doctor Name: _____ ☐ **NONE**					
Last Seen:	☐ within the past 3 months	☐ within the past 6 months	☐ within the past 1 year	☐ within the past 2 years	☐ greater than 2 years

Medical History:

☐ **No Medical Conditions**

Please check only current or past medical conditions below.

Asthma	☐ History	☐ Active – treated	☐ Active – not treated
Cancer	☐ History	☐ Active – treated	☐ Active – not treated
COPD	☐ History	☐ Active – treated	☐ Active – not treated
Dental Problems	☐ History	☐ Active – treated	☐ Active – not treated
Diabetes Type 1	☐ History	☐ Active – treated	☐ Active – not treated
Diabetes Type 2	☐ History	☐ Active – treated	☐ Active – not treated
Head Injury	☐ History	☐ Active – treated	☐ Active – not treated
Hearing loss/issues	☐ History	☐ Active – treated	☐ Active – not treated
Hyperlipidemia (high cholesterol)	☐ History	☐ Active – treated	☐ Active – not treated
Heart disease	☐ History	☐ Active – treated	☐ Active – not treated
Hepatitis A	☐ History	☐ Active – treated	☐ Active – not treated
Hepatitis B	☐ History	☐ Active – treated	☐ Active – not treated
Hepatitis C	☐ History	☐ Active – treated	☐ Active – not treated
HIV	☐ History	☐ Active – treated	☐ Active – not treated
Liver disease	☐ History	☐ Active – treated	☐ Active – not treated
Obesity	☐ History	☐ Active – treated	☐ Active – not treated
Renal (Kidney) Disease	☐ History	☐ Active – treated	☐ Active – not treated
Hypertension (high blood pressure)	☐ History	☐ Active – treated	☐ Active – not treated
Seizures	☐ History	☐ Active – treated	☐ Active – not treated
Stroke	☐ History	☐ Active – treated	☐ Active – not treated
Thyroid disease	☐ History	☐ Active – treated	☐ Active – not treated
Tuberculosis (TB)	☐ History	☐ Active – treated	☐ Active – not treated
Vision/eye condition	☐ History	☐ Active – treated	☐ Active – not treated
Other _____	☐ History	☐ Active – treated	☐ Active – not treated
Other _____	☐ History	☐ Active – treated	☐ Active – not treated

Continued on Back

Physical Pain	☐ None	☐ History	☐ Active – treated	☐ Active – not treated

If active, complete below (If not, skip to Nutritional History)

Pain Condition/Location: _____

How does your pain affect your functioning? Mildly Limiting Moderately Limiting Severely Limiting

Pain Intensity: Circle the number that best describes your pain.

	None			Mild		Uncomfortable		Serious			Excruciating
What is the worst it gets?	0	1	2	3	4	5	6	7	8	9	10
What is the least it gets?	0	1	2	3	4	5	6	7	8	9	10
What is it now?	0	1	2	3	4	5	6	7	8	9	10

Nutritional History: Check all that apply

Efforts to avoid weight gain:	☐ Yes (complete below)	☐ NA
☐ Purging/self-induced vomiting	☐ Use of laxative/diuretics/enemas	☐ Fasting/extreme intake restriction
☐ Excessive Exercise	☐ Bingeing/loss of control of eating	☐ Food dominates thoughts/life

Weight Change	**Other**	
☐ Weight Loss of 15 or more pounds in the last 90 days	☐ Recent change in appetite/food intake	☐ Difficulty chewing or swallowing
☐ Weight Gain of 15 or more pounds in the last 90 days	☐ Special diet/food restrictions: _____	☐ **None**

Drug/Medication History: Please list all medications you are currently taking (include vitamins, herbals, or over-the-counter medications)

☐ NO Medications

Drug/Medication	Dose	Frequency	Drug/Medication	Dose	Frequency
1			5		
2			6		
3			7		
4			8		

Drug/Medication Allergies: Please list all known medication or drug allergies

☐ NO known drug or medication allergies

Drug/Medication	Reaction	Drug/Medication	Reaction
1		4	
2		5	
3		6	

Food/Other Allergies: Please list all known food or other allergies

☐ NO known food or other allergies

Food/Other	Reaction	Food/Other	Reaction
1		4	
2		5	
3		6	

Hospitalizations or Major Surgery: Please list any hospitalizations or surgeries

☐ None

Hospital	Date	Reason