

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: _____					<input type="checkbox"/> NONE
Last Seen:	<input type="checkbox"/> within the past 3 months	<input type="checkbox"/> within the past 6 months	<input type="checkbox"/> within the past 1 year	<input type="checkbox"/> within the past 2 years	<input type="checkbox"/> greater than 2 years

Dentist Name: _____					<input type="checkbox"/> NONE
Last Seen:	<input type="checkbox"/> within the past 3 months	<input type="checkbox"/> within the past 6 months	<input type="checkbox"/> within the past 1 year	<input type="checkbox"/> within the past 2 years	<input type="checkbox"/> greater than 2 years

Eye Doctor Name: _____					<input type="checkbox"/> NONE
Last Seen:	<input type="checkbox"/> within the past 3 months	<input type="checkbox"/> within the past 6 months	<input type="checkbox"/> within the past 1 year	<input type="checkbox"/> within the past 2 years	<input type="checkbox"/> greater than 2 years

Medical History:			
<input type="checkbox"/> No Medical Conditions			
Please check only current or past medical conditions below.			
Asthma	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Cancer	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
COPD	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Dental Problems	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Diabetes Type 1	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Diabetes Type 2	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Head Injury	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Hearing loss/issues	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Hyperlipidemia (high cholesterol)	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Heart disease	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Hepatitis A	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Hepatitis B	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Hepatitis C	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
HIV	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Liver disease	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Obesity	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Renal (Kidney) Disease	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Hypertension (high blood pressure)	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Seizures	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Stroke	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Thyroid disease	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Tuberculosis (TB)	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Visi on/eye condition	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Other _____	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated
Other _____	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> Active – not treated

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DO NOT FILE

Physical Pain	<input type="checkbox"/> None	<input type="checkbox"/> History	<input type="checkbox"/> Active – treated	<input type="checkbox"/> 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:	<input type="checkbox"/> Yes (complete below)	<input type="checkbox"/> NA
<input type="checkbox"/> Purging/self-induced vomiting	<input type="checkbox"/> Use of laxative/diuretics/enemas	<input type="checkbox"/> Fasting/extreme intake restriction
<input type="checkbox"/> Excessive Exercise	<input type="checkbox"/> Bingeing/loss of control of eating	<input type="checkbox"/> Food dominates thoughts/life
Weight Change	Other	
<input type="checkbox"/> Weight <u>Loss</u> of 15 or more pounds in the last 90 days	<input type="checkbox"/> Recent change in appetite/food intake	<input type="checkbox"/> Difficulty chewing or swallowing
<input type="checkbox"/> Weight <u>Gain</u> of 15 or more pounds in the last 90 days	<input type="checkbox"/> Special diet/food restrictions: _____	<input type="checkbox"/> None

Drug/Medication History: Please list all medications you are currently taking (include vitamins, herbals, or over-the-counter medications)					
<input type="checkbox"/> 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			
<input type="checkbox"/> 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 medication or drug allergies			
<input type="checkbox"/> NO known drug or medication allergies			
Food/Other	Reaction	Food/Other	Reaction
1		4	
2		5	
3		6	

Hospitalizations or Major Surgery: Please list any hospitalizations or surgeries		
<input type="checkbox"/> None		
Hospital	Date	Reason