Name: _____

DOB: _____

OR LABEL

# PERSONAL HEALTH ASSESSMENT

Behavioral Health Services
Agnesian HealthCare



**PRIMARY CARE PROVIDER:**

**YES NO**

❑ ❑ Do you regularly see a primary care provider?

Who is your primary care provider? _____

Where are they located? _____

❑ ❑ Have you had a physical in the last year? (*over a year refer to PCP*)? When? _____

❑ ❑ Have you had any medical hospitalizations in the last year? If yes, please list: _____

_____

❑ ❑ Do you have any allergies? If yes, please list: _____

_____

_____

**MEDICATIONS: (include supplements, vitamins, or any over-the-counter medications):**

| Medication | Dose | Date you started medication | Reason for taking the medication | Medication prescribed by |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |

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# PERSONAL HEALTH ASSESSMENT

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## SLEEP:

How many hours of sleep do you get a night? _____

| YES | NO | If you answer yes, give the reason for the sleep problem if known (mind races/caffeine use etc.) If you have nightmares, can you recall about what? |
|---|---|---|
| ❑ | ❑ | Do you have problems falling asleep? _____ |
| ❑ | ❑ | Do you have nightmares? _____ |
| ❑ | ❑ | Do you feel rested when you wake up? _____ |
| ❑ | ❑ | Do you use a CPAP machine? _____ |
| ❑ | ❑ | Do you take any sleeping medication? _____ |
| ❑ | ❑ | Any other sleep issues? _____ |

## NUTRITION:

How many meals do you eat per day? _____

How much caffeine do you drink per day? _____

How many energy drinks do you drink per day? _____

### Beliefs/attitude about food

| YES | NO | How much and reason why (stress, diet, etc.) |
|---|---|---|
| ❑ | ❑ | Have you gained weight in the past year? _____ |
| ❑ | ❑ | Have you lost any weight in the past year? _____ |
| ❑ | ❑ | Are there any foods you fear (due to calories/fat etc.)? _____ |
| ❑ | ❑ | Are there any foods you won't eat (don't like/allergies to etc.)? _____ |

### Behaviors around food

| YES | NO | PAST | PRESENT | Comments |
|---|---|---|---|---|
| ❑ | ❑ | ❑ | ❑ | Do you purge? (force yourself to vomit)? _____ |
| ❑ | ❑ | ❑ | ❑ | Do you overeat? _____ |
| ❑ | ❑ | ❑ | ❑ | Do you restrict your food intake? _____ |
| ❑ | ❑ | ❑ | ❑ | Do you you take laxatives or diet pills? _____ |
| ❑ | ❑ | ❑ | ❑ | Do you have negative thoughts about your body or looks? _____ |

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## EXERCISE:

**YES NO**

❑ ❑ Do you currently engage in exercise that raises your heart rate?

Type of exercise you engage in?_____

_____

How often per week do you exercise? ❑ 1-2 days ❑ 3-4 days ❑ 5-6 days ❑ 7 days

How long are the exercise sessions? ❑ 0-15 minutes ❑ 15-30 minutes ❑ 30-45 minutes ❑ 45-60 + minutes

## SMOKING:

**YES NO**

❑ ❑ Do you currently use tobacco products? If yes, type:_____

❑ ❑ Have you tried to quit? If yes, how many times? _____

❑ ❑ Do you want resources on how to quit smoking? ❑ Declined

## CURRENT/PAST SUBSTANCE USE/ABUSE: *If not applicable, check here:* ❑

| Substance | Currently Using | Past Use | How often do you use? | Date of last use |
|---|---|---|---|---|
| Alcohol | ❑ Yes ❑ No | ❑ Yes ❑ No | | |
| Cocaine | ❑ Yes ❑ No | ❑ Yes ❑ No | | |
| Heroin | ❑ Yes ❑ No | ❑ Yes ❑ No | | |
| Marijuana | ❑ Yes ❑ No | ❑ Yes ❑ No | | |
| Pills | ❑ Yes ❑ No | ❑ Yes ❑ No | | |
| IV drug use | ❑ Yes ❑ No | ❑ Yes ❑ No | | |

## FIREARMS:

**YES NO**

❑ ❑ Are there firearms in the home/apartment?

❑ ❑ Are they locked in a cabinet?

❑ ❑ Is the gun locked?

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## PAST/CURRENT MEDICAL HEALTH ISSUES:

***Have you been treated for or experienced:***

| YES | NO | If you answer yes, explain where/how often you experience the condition/length of the illness/are you currently being treated for the pain and by whom. |
|---|---|---|
| ❑ | ❑ | Do you have muscle tension? _____ |
| ❑ | ❑ | Do you have headaches? _____ |
| ❑ | ❑ | Do you have migraines? _____ |
| ❑ | ❑ | Have you had a traumatic head injury (if yes-open or closed)? _____ |
| ❑ | ❑ | Epilepsy or seizure disorder? _____ |
| ❑ | ❑ | Heart or lung disease? _____ |
| ❑ | ❑ | Hypoglycemia (low blood sugar)? _____ |
| ❑ | ❑ | Diabetes? _____ |
| ❑ | ❑ | Hypertension (high blood pressure)? _____ |
| ❑ | ❑ | Thyroid? _____ |
| ❑ | ❑ | Cancer? _____ |
| ❑ | ❑ | Arthritis? _____ |
| ❑ | ❑ | Have you had multiple episodes of strep throat? _____ |
| ❑ | ❑ | Recurrent ear infections? _____ |
| ❑ | ❑ | Ever had a broken bone? _____ |
| ❑ | ❑ | Are you frequently in pain? _____ |
| ❑ | ❑ | Are you seeing anyone for your pain? _____ |
| ❑ | ❑ | Have you ever tested positive for TB? _____ |
| ❑ | ❑ | Were you treated for TB? _____ |
| ❑ | ❑ | Any other medical problems? _____ |

Name: _____

DOB: _____

OR LABEL

# PERSONAL HEALTH ASSESSMENT

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## RISK FACTORS FOR INFECTIOUS DISEASE:

***Have you been treated for or experienced:***

| YES | NO | If you answer yes, explain where/how often you experience the condition/length of the illness/are you currently being treated for the pain and by whom. |
|---|---|---|
| ❑ | ❑ | Do you have/had unprotected sex with multiple partners? _____ |
| ❑ | ❑ | Have you been treated for a STD _____ |
| ❑ | ❑ | Have you tested positive for HIV? _____ |
| ❑ | ❑ | Are you currently pregnant? _____ |
| ❑ | ❑ | Have you ever had a miscarriage? _____ |
| ❑ | ❑ | Have you ever had an abortion? _____ |
| ❑ | ❑ | Have you had a blood transfusion? _____ |

## PLEASE CIRCLE THE NUMBER THAT BEST MATCHES YOUR RESPONSE:

**Rate your current physical health:**

1 2 3 4 5 6 7 8 9 10
Poor Excellent

**Is your physical health impairing your current ability to function?**

1 2 3 4 5 6 7 8 9 10
Not at all Severely

**Rate your current mental health:**

1 2 3 4 5 6 7 8 9 10
Poor Excellent

**Is your mental health impairing your current ability to function?**

1 2 3 4 5 6 7 8 9 10
Not at all Severely

_____

**PATIENT/GUARDIAN SIGNATURE**

_____

**DATE** **TIME**

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