Capital Biofeedback, Inc.
Patient Survey

Name _____ Date _____ Date of Birth _____ Age _____
Sex: _____ M _____ F

HEALTH PERCEPTION/HEALTH MANAGEMENT
Present Health Status

1. In general, please rate your overall health (please circle a number):
   0 1 2 3 4 5 6 7 8 9 10
   unhealthy/ill very healthy

3. Blood pressure problems? Yes No
   If yes: For how many years _____ ?
   Range of blood pressure _____
   Have you ever been treated with medication? Yes No
   Are you being treated now? Yes No

4.a. List any prescribed medications and doses you are currently taking.
   Name Dose Frequency
   _____
   _____
   _____
   _____
   _____

b. How often do you forget to take your medications?
   never occasionally once a day more than once a day

c. List any over-the-counter medications (including aspirin) or dietary supplements (i.e. vitamins/minerals) you are currently taking.
   Name Dose Frequency
   _____
   _____
   Have your medications ever caused you any unusual side-effects or problems? If so, please describe:
   _____
   _____

7. Do you have any drub/food allergies? Yes No
   If yes, please list: _____
   _____

PAST HEALTH STATUS

1. Have you ever had any of the following?

_____Anemia	_____Phlebitis
_____Anxiety/depression	_____Rheumatic Fever
_____Arthritis	_____Seizures
_____Asthma	_____Sleeping Disorders
_____Dizziness/fainting	_____Stroke
_____Heart murmur	_____Thyroid Problems
_____Injuries to back, arms, legs	_____Broken Bones

_____Other (please specify)_____

2. Do you have a primary care physician? Yes No
   Name and Address: _____
   _____
   Telephone: _____

3.a. Have you ever sought counseling? Yes No
   If yes, please indicate type of counselor: _____
   Please indicate when: _____

b. Are you currently in treatment with a _____psychiatrist, _____psychiatrist, _____social worker, _____ therapist or _____ other type of counselor? (Please check all that apply)
   If yes, how long in treatment? _____
   How often do you meet? _____

c. Have you found this support helpful? (Please circle a number.)

1	2	3	4	5
not at all		somewhat		very helpful

HEALTH HABITS

1. Do you smoke cigarettes? Yes No
   If yes: a. How many packs a day? _____
   b. For how many years?_____
   c. Have you ever stopped smoking in the past? Yes No
   d. How soon after you wake up do you smoke your first cigarette?
   _____ within 30 min. _____ after 30 min.
   e. Do you find it difficult to refrain from smoking in places where it is forbidden, such as in church, at the library, in the cinema, etc? Yes No
   f. Which cigarette would you most hate to give up?
   g. How many cigarettes per day do you smoke?
   _____15 or less _____16-25 _____26 or more
   h. Do you smoke more frequently during the first hours after awakening than

during the rest of the day? Yes No

i. Do you smoke even if you are so ill that you are in bed most of the day?
Yes No

j. What is the nicotine level of your usual cigarette brand?
____0.9mg or less _____1.0-1.2mg _____1.3mg or more

k. Do you inhale? ____never ____sometimes ____always

If no: Did you ever smoke cigarettes? Yes No

a. When was the date of your last cigarette? _____
b. Did you stop on your own? Yes No
c. Number of packs/day _____
d. For how many years? _____
e. Does anyone in your home smoke? Yes No
If yes, whom? _____

2. Do you drink alcohol? Yes No

If yes: wine (glasses/wk)____ beer (glasses/wk)____ alcohol (oz/wk)_____

a. Have you ever felt you should cut down on your drinking? Yes No
b. Have people annoyed you by criticizing your drinking? Yes No
c. Have you ever felt bad or guilty about your drinking? Yes No
d. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hang-over (eye-opener0? Yes No

3. Do you use recreational drugs? Yes No

_____Cocaine _____Other (please list) _____

NUTRITION/METABOLIC

1.a. Do you consider yourself: _____overweight _____underweight _____about right?

b. What is your ideal weight?_____ Has your weight changed recently? _____

c. Have you ever been seen by a dietitian for nutrition counseling? Yes No
If yes, where? _____

2.a. Do you follow a special food plan?
If so, is it _____ low sodium _____ low fat and cholesterol _____ low calorie
_____ other (describe) _____

b. How much of the time do you follow your food plan?
_____ always _____ usually _____about half the time _____ occasionally ____ low calorie

3.a. Do any of the factors listed below make it difficult for you to eat right?
_____ eating out _____ frequent snacking _____ dislike recommended food
_____ moods _____ some one else cooks _____ taking large portions
_____ lack of information on healthful eating
_____ other (describe) _____

b. Who shops in your household? _____

c. Who cooks? _____

4.a. How many time per week do you usually eat out? _____

b. Where? (restaurant, cafeteria, friend's house, etc.)

_____

5. Do you salt your food? Yes No

6. Do you drink caffeinated beverages? Yes No
If yes, please indicate the number of cups per day of the following:
_____ coffee _____ tea _____cola _____cocoa

7. What foods do you usually choose for snacks?

_____

8. Are there any foods that you try to avoid? Yes No
If yes, what? _____

9. Are there any changes that you would like to make in your eating behaviors?

_____

_____

ACTIVITY/EXERCISE

1. How active are you? _____ very _____ moderately _____ sedentary

2. Has this changed recently? Yes No
If so, why? _____

_____

3. Do you have any physical problems that limit your activity? Yes No
If yes, please describe: _____

_____

4. If you currently exercise on a regular basis, please complete the following

ACTIVITY (walking, biking, swimming, weights, etc.)	# SESSIONS/ WEEK	MINUTES/SESSION
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. What types of activity do you do around the house or in your leisure time (i.e. housework, gardening, woodworking, etc.)?

_____

_____

_____

6. If you are beginning a regular exercise program, what type of exercise would you most like to do?

_____

_____

SLEEP/REST

1.a. Number of hours of sleep per night: _____
b. Do you generally feel rested upon awakening? Yes No

2.a. Do you nap? Yes No duration: _____
b. Do you generally feel rested upon awakening? Yes No

3. Do you have problems with insomnia? Yes No
If yes, please specify: _____

_____

4. Do you use sleep aids? Yes No
If yes, please specify: _____

_____

COGNITIVE/ PERCEPTUAL

1. Do you have any hearing difficulty? Yes No
If yes, please specify: _____

_____

2. Do you have any visual problems? Yes No
If yes, please specify: _____

_____

3. Do you have any learning difficulties? Yes No
If yes, please specify: _____

_____

SELF-PERCEPTION/SELF-CONCEPT

1. On a scale of 0 to 10, please rate your general sense of self-confidence:

0 1 2 3 4 5 6 7 8 9 10
not confident very confident

2. List three things you like about yourself: _____

_____

3. List three things you would like to change about yourself: _____

_____

4. Do you believe you experience any of the following feelings more often than most people (check all that apply)?

_____ fear	_____ anxiety	_____ lack of control
_____ isolation	_____ depression	_____ hostility
_____ anger	_____ helplessness	_____ hopelessness
_____ guilt	_____ shame	_____ sadness

5. On a scale of 0 to 10, please rate how successful you feel that you will be in achieving your personal goals in this program (i.e. lose weight, stop smoking, etc.):

0	1	2	3	4	5	6	7	8	9	10
very unsuccessful										very successful

ROLE/RELATIONSHIP

1. Marital status (please check one):

_____ married _____ single _____ living in a committed relationship _____ divorced
_____ separated _____ widowed

2. Number of children: _____ Ages: _____ How many at home? _____

3. How many people line in your household? _____

4. Education level completed (please circle the appropriate number):

Grade School	High School	College	Grad. School
1 2 3 4 5 6 7 8	9 10 11 12	13 14 15 16	17 18 19 20 20+

5. Are you currently employed? Yes No
If yes, occupation: _____

If no, reason: _____

6. How many roles do you have? (please circle all that apply)
_____ friend _____ child _____ parent _____ employer
_____ employee _____ spouse _____ caretaker _____ community volunteer
_____ other (please specify): _____

7. What resources do you have for emotional support? (please check all that apply):
_____ spouse _____ family _____ friends _____ religious/spiritual _____ pets
_____ other (please specify): _____

SEXUALITY/REPRODUCTION

1. Has your illness/health condition interfered with your usual pattern of sexual activity? ____ Yes ____ NO

2. Are you satisfied with your sex life? _____ Yes _____ No

3. Women Only:
   Are you menopausal? _____ Yes _____ No For how long? _____ years
   Do you take estrogen replacement? _____ Yes _____ No
   List prescribed medication and dose:
   Name Dose Frequency
   _____

   _____

STRESS/COPING

1. Do you feel you have an excessive amount of stress in your life? _____ Yes _____ No

2. What is your perception of daily stressors which may interfere with your life? (please circle the number corresponding to each, 1 being no stress and 10 being the worst stress possible.)

Work	1	2	3	4	5	6	7	8	9	10
Family	1	2	3	4	5	6	7	8	9	10
Social	1	2	3	4	5	6	7	8	9	10
Finances	1	2	3	4	5	6	7	8	9	10
Health	1	2	3	4	5	6	7	8	9	10
Other	1	2	3	4	5	6	7	8	9	10

   Please specify: _____

3. Do you meditate or practice a relaxation technique? _____ Yes _____ No

   If yes, please check those that apply:

   _____ yoga _____ imagery _____ abdominal breathing
   _____ meditation _____ Tai Chi _____ progressive muscle relaxation
   _____ prayer _____ other: _____

4. Have you ever been abused, a victim of a crime, or experienced a trauma? _____ Yes _____ No

5. Where do you hold tension in your body? _____

6. How do you release muscular tension? _____

7. What do you do to calm your mind and emotions? _____

8. Do you feel you can easily handle the stress in your life? _____ Yes _____ No

VALUES/BELIEFS

1. What is valuable and meaningful to you in your life?

   _____

   _____

2. Do you have a religious orientation or belief system that supports you? _____ Yes _____ No
   Please describe: _____

   _____

3. What is your motivation for enrolling in this program at this time?

   _____

   _____

4. What are the three most important goals that you hope to achieve during this program?

   1. _____
   2. _____
   3. _____

For Office Use Only:

_____

_____

_____

_____

Signed by:_____