

PAST HEALTH STATUS

1. Have you ever had any of the following?

- | | |
|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Anxiety/depression | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sleeping Disorders |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Injuries to back, arms, legs | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> 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-opener)? 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?

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

<input type="checkbox"/> fear	<input type="checkbox"/> anxiety	<input type="checkbox"/> lack of control
<input type="checkbox"/> isolation	<input type="checkbox"/> depression	<input type="checkbox"/> hostility
<input type="checkbox"/> anger	<input type="checkbox"/> helplessness	<input type="checkbox"/> hopelessness
<input type="checkbox"/> guilt	<input type="checkbox"/> shame	<input type="checkbox"/> 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):

<input type="checkbox"/> married	<input type="checkbox"/> single	<input type="checkbox"/> living in a committed relationship	<input type="checkbox"/> divorced
<input type="checkbox"/> separated	<input type="checkbox"/> widowed		

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

3. How many people live 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)

<input type="checkbox"/> friend	<input type="checkbox"/> child	<input type="checkbox"/> parent	<input type="checkbox"/> employer
<input type="checkbox"/> employee	<input type="checkbox"/> spouse	<input type="checkbox"/> caretaker	<input type="checkbox"/> community volunteer
<input type="checkbox"/> other (please specify): _____			

7. What resources do you have for emotional support? (please check all that apply):

<input type="checkbox"/> spouse	<input type="checkbox"/> family	<input type="checkbox"/> friends	<input type="checkbox"/> religious/spiritual	<input type="checkbox"/> pets
<input type="checkbox"/> 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. _____

<p>For Office Use Only:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p style="text-align: right;">Signed by: _____</p>
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