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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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? ____________

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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**

Assessment