simplexhealth

Health Assessment

Please write or print clearly. All of your information will remain confidential between you and the Dietitian.

PERSONAL INFORMATION

First Name: ______________________________

Last Name: ______________________________

Email: ______________________________

Address: ______________________________

Phone: ______________

Birthdate: ______________

Health Insurance:______________ Member ID: ______________

Current weight: _______ Highest Weight (Adult): ________ Lowest Weight (Adult): __________

Would you like your weight to be different? If so, what?

____

____

____

SOCIAL INFORMATION

Relationship status: ______________________________

Where do you currently live? ______________________________

Children: ______________ Pets: ______________

Occupation: ______________ Hours of work per week: ______________

How often do you use tobacco: ______________ How often do you drink? ______________

HEALTH INFORMATION

Please list your main health concerns:

____

____

____

____

Other concerns and/or goals?

____

____

____

At what point in your life did you feel best?

____

____

Any serious illnesses/hospitalizations/injuries?

____

____

____

How is/was the health of your mother?

____

How is/was the health of your father?

____

How many hours of sleep? ____________ Do you wake up at night? Y / N

Why? ____

Constipation/Diarrhea/Gas? ____

Allergies or sensitivities? Please explain:

____

____

____

MEDICAL INFORMATION

Do you take any supplements or medications? Please list:

____

____

____

What role do sports and exercise play in your life?

____

How often do you exercise/move per week? ___________________________________

Please check all that apply

Respiratory

▯ Asthma ▯ Snoring ▯ Emphysema ▯ Sleep apnea ▯ History of pneumonia ▯ Chronic bronchitis

Cardiovascular

▯ High blood pressure ▯ Heart disease/heart attack ▯ Congestive heart failure ▯ Blood clot

Gastrointestinal

▯ Nausea/vomiting ▯ Abdominal pain ▯ Heartburn ▯ Ulcer disease ▯ Colitis ▯ Constipation ▯ Chron's
▯ Diarrhea ▯ Gallbladder/stones ▯ Celiac Disease ▯ IBS

Musculoskeletal

▯ Aching muscles/joints ▯ Arthritis ▯ Back Pain ▯ Osteoporosis/Osteopenia

Endocrine

▯ Diabetes Mellitus ▯ Thyroid Disease ▯ Elevated cholesterol ▯ Elevated Triglycerides ▯ Gout

Emotions, Energy, and Mind

▯ Mood swings ▯ Anxiety ▯ Anger/Irritability ▯ Depression ▯ Fatigue/sluggishness ▯ Lethargy
▯ Hyperactivity ▯ Poor memory ▯ poor concentration

Skin

▯ Ance ▯ Hives/rashes/dry skin ▯ Hair loss ▯ excessive sweating ▯ hot flashes

FOOD INFORMATION

What do you normally eat in a day?

Breakfast	Lunch	Dinner	Snacks	Liquids
______________	______________	______________	______________	______________
______________	______________	______________	______________	______________
______________	______________	______________	______________	______________
______________	______________	______________	______________	______________

Do you skip meals? ____

Do you crave certain foods? ____

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? ____

____

Do you cook? Y / N What percentage of your food is home-cooked? ______________

Where do you get the rest from? ____

Have you tried any other diets or lifestyle changes in the past to improve health/weight?

____

____

Do you crave sugar, coffee, cigarettes, or have any major addictions?

____

____

What are you currently doing to embrace a healthier lifestyle?

____

____

____

ADDITIONAL COMMENTS Anything else you would like to share? _______________________

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