The missing link between health and performance

Comprehensive Health-Performance Assessment
Questionnaire and Intake Form

Name: _____ **Date of Birth:** _____/_____/_____
Please print your full name **MM DD YYYY**

Address: _____

_____

Text_____

Today's Date: _____/_____/20____
MM DD YY

Instructions: The objective of this intake form is to gather information with regard to your health and functional status or life performance. The information that you provide in this intake form and any information you disclose to me personally during our face to face meetings will remain completely confidential and under the protection of the HIPAA privacy rules.

Health and Well-Being Self Rating

On a scale from 1 to 10 with 1 being terrible and 10 being excellent, please rate your overall health or sense of well being:

(Please circle the best answer below.)

1 2 3 4 5 6 7 8 9 10

Spontaneously Elicited Symptoms

Using just two or three word descriptions please list all symptoms that you feel may be keeping you from rating your overall health at "10": Examples are back pain, fatigue, depressed, worried, angry, abdominal pain, hot flashes, night sweats, frustrated, tired, bored, trouble sleeping, money issues; anything and everything is fair game, so please do not hold back. I am requesting, for the purposes of this **Intake Form** that you restrict your descriptions to just two or three words. I do not want this section to take more than a few minutes to complete. Do not worry if your complaints do not seem "medical". If it bothers you, it's a symptom in my book, and I want to write it down here. We will sort through this information in more detail at the time of our face to face meeting.

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Performance Self Assessment

On a scale from 1 to 10 with 1 being terrible and 10 being excellent, please rate your **performance** in the following life areas. How well do you think you are doing? (Please circle, **NA** if not applicable to you.)

School life

(Please circle the best answer below)

NA **1 2 3 4 5 6 7 8 9 10**

Work life

(Please circle the best answer below)

NA **1 2 3 4 5 6 7 8 9 10**

Home life

(Please circle the best answer below)

1 2 3 4 5 6 7 8 9 10

Social life

(Please circle the best answer below)

1 2 3 4 5 6 7 8 9 10

School Performance Assessment (please answer regardless if you are currently in school or not)

- What was the last year of school you completed (High School is 9th thru 12th, College starts with 13th, etc.)?
- What was your grade point average?
- What did you score on ACTs and/or SATs?

Workplace Performance Assessment

At your current workplace, do you receive a formal appraisal?

YES_____ NO_____

Brief Job Description

Please state your current title and provide a brief description of your job description:

Review of Systems

Do you experience any of the symptoms listed below? Please check the box adjacent to any of the symptoms listed below that you may have experienced. Please do not write in any additional commentary at this time. Positive responses will be reviewed in detail at the time of our face to face meeting.

Cardiovascular

- ☐ Chest discomfort, pressure, tightness or pain
- ☐ A recent decline in your exercise capacity
- ☐ Rapid heartbeats (palpitations)
- ☐ Feeling faint
- ☐ Unexplained sweats (without physical exertion)

Peripheral Vascular:

- ☐ Need to stop walking due to calf pain
- ☐ Sores on the legs or feet that are slow to heal
- ☐ Purplish discoloration of the fingers or toes
- ☐ Swelling of the feet ankles or legs

Respiratory

- ☐ recurrent sinus or bronchial infections
- ☐ post nasal drip ☐ ear infections ☐ shortness of breath
- ☐ a recent decline in your breathing ☐ A chronic cough ☐ Chronic sputum production
- ☐ Wheezing ☐ Coughing blood

Nervous System

- ☐ Headaches ☐ Seizures ☐ Temporary visual loss or changes
- ☐ Spontaneous loss of consciousness ☐ Head injury that has led to loss of consciousness
- ☐ Difficulty in finding words
- ☐ Temporary loss of strength in any part of your face or body

Gastrointestinal System

- ☐ abdominal pain ☐ abdominal cramping ☐ abdominal pain with eating
- ☐ abdominal or chest discomfort when eating ☐ abdominal pain that wakes you from sleep
- ☐ abdominal pain that radiates to your back ☐ vomiting
- ☐ nausea ☐ heartburn ☐ bloating
- ☐ constipation ☐ diarrhea ☐ blood in the stool
- ☐ a recent change in your bowel function ☐ anal itching, bleeding or discomfort

Male Urinary Tract (For Men Only)

- ☐ a decrease in the force of your urinary stream
- ☐ getting up more than once per night to urinate
- ☐ erectile dysfunction ☐ penile discharge ☐ premature ejaculation
- ☐ burning on urination ☐ blood in your urine
- ☐ urinary incontinence (accidental loss of urine) ☐ history of kidney stones

Female Urinary Tract (For Women Only)

- ☐ more than one urinary tract infection in the past year
- ☐ urinary incontinence (accidental loss of urine)
- ☐ burning on urination ☐ blood in your urine ☐ history of kidney stones

Menstrual and Pregnancy History (For Women Only)

- ☐ menopause such as loss or change of your normal menstrual period or hot flashes
- ☐ mood changes or anxiety during or after a pregnancy that impaired your daily functioning
- ☐ difficulty becoming pregnant
- ☐ more than a single miscarriage
- ☐ mood changes or anxiety around your menstrual period that causes impairment in your daily functioning
- ☐ headaches around your menstrual period significant enough to cause impairment in your daily functioning
- ☐ excessive menstrual bleeding compared to before
- ☐ menstrual cramps or pain significant enough to require medication or impair your daily functioning
- ☐ uterine breakthrough and or bleeding between your menstrual periods

Skin

☐ Dry skin ☐ Itchy Skin ☐ Rashes ☐ Pigmented spots that have become larger

Musculoskeletal

☐ Pain or swelling in your joints ☐ Muscular pain ☐ Back
☐ Ankles ☐ Knees ☐ Hips ☐ Legs ☐ Toes
☐ Neck ☐ Shoulders ☐ Arms ☐ Wrists ☐ Fingers

Sleep Habits

- ☐ difficulty falling asleep at night ☐ difficulty staying asleep
- ☐ loud snoring witnessed by a sleep partner
- ☐ abnormal breathing during sleep witnessed by a bed partner
- ☐ abnormal leg movements while sleeping or trying to fall asleep
- ☐ excessive daytime sleepiness ☐ sleepy Driving
- ☐ falling asleep at work ☐ falling asleep in public places such as movie theaters

Past Medical History

Please check any of the following conditions that apply to you:

___Abnormal Heart Rhythm ___Addictions (Drugs or Alcohol) ___Anemia ___Arthritis ___Asthma

___Bleeding Disorder ___Blood Clots

___Cancer (Please list type and location):_____

___Chronic Bronchitis ___Crohn's Disease ___Diabetes ___ Eating Disorders ___Emphysema

___Gall Bladder Stones ___Heart Disease ___High Blood Pressure ___High Cholesterol ___HIV/AIDS

___Irritable Bowel Disorder ___Kidney Stones ___Seizure Disorder ___Sexually Transmitted Diseases

___Stomach Ulcer ___Stroke or TIA (mini stroke) ___Thyroid Disorder ___Ulcerative Colitis

Family Health History

Has any member of your immediate family (father, mother, siblings) ever had or currently have any of the conditions listed below?

☐ Adult Onset (Type 2) Diabetes

☐ A heart attack, sudden death, artery bypass surgery, angioplasty or angina before the age of 60

☐ A Stroke, TIA (mini stroke) or carotid surgery before the age of 60

☐ Breast Cancer ☐ Prostate Cancer ☐ Ovarian cancer ☐ Colon Cancer before the age of 70

☐ Major Depressive Disease; Bipolar Disorder; Schizophrenia; Psychosis; Suicide

☐ Attention Deficit Hyperactivity Disorder (ADHD)

Mental Health Screeners and History

Please answer the questions below rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, circle the correct number that best describes how you have felt and conducted yourself over the past months.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you make careless mistakes when doing boring or difficult work?	**0**	**1**	**2**	**3**	**4**
2. How often do you have difficulty keeping your attention when doing boring or difficult work?	**0**	**1**	**2**	**3**	**4**
3. How often do you have difficulty concentrating on what people say to you, even When they are speaking to your directly?	**0**	**1**	**2**	**3**	**4**
4. How often do you have difficulty wrapping up the final details of a project, once the challenging parts have been done?	**0**	**1**	**2**	**3**	**4**
5. How often do you have difficulty getting things in order when you have to do a task that requires organization?	**0**	**1**	**2**	**3**	**4**
6. When you have a task that requires allot of thought, how often do you avoid or delay in getting starts?	**0**	**1**	**2**	**3**	**4**
7. How often do you misplace or have difficulty finding things at home or work?	**0**	**1**	**2**	**3**	**4**
8. How often are you distracted by activity or noise around you?	**0**	**1**	**2**	**3**	**4**
9. How often do you have problems remembering appointments or obligations?	**0**	**1**	**2**	**3**	**4**
10. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	**0**	**1**	**2**	**3**	**4**
11. How often do you leave your seat in a meeting or other situations in which your are expected to ream seated?	**0**	**1**	**2**	**3**	**4**
12. How often do you feel restless or fidgety?	**0**	**1**	**2**	**3**	**4**
13. How often do you have difficulty unwinding and relaxing when you have time to yourself?	**0**	**1**	**2**	**3**	**4**
14. How often do you feel overly active and compelled to do things, like you were driven by a motor?	**0**	**1**	**2**	**3**	**4**
15. How often do you find yourself talking to much when you are in a social situation?	**0**	**1**	**2**	**3**	**4**
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you're are talking to, before they can finish them themselves?	**0**	**1**	**2**	**3**	**4**
17. How often do you have difficulty waiting your turn in situations when turn talking is required?	**0**	**1**	**2**	**3**	**4**
18. How often do you interrupt others when they are busy?	**0**	**1**	**2**	**3**	**4**

Please check ONE BOX ONLY for each of the questions below

YES NO

- Has there ever been a period of time when you were not your usual self and you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?
  ☐ ☐
- You were so irritable that you shouted at people or started fights and arguments?
  ☐ ☐
- You felt much more self-confident than usual?
  ☐ ☐
- You got much less sleep than usual and found you didn't really miss it?
  ☐ ☐
- You were much more talkative and/or spoke much faster than usual?
  ☐ ☐
- Thoughts raced through your head and/or you couldn't slow down?
  ☐ ☐
- You were so easily distracted by things around you that you had trouble concentrating or staying on track?
  ☐ ☐
- You had much more energy than usual?
  ☐ ☐
- You were much more social or outgoing than usual for example, you telephoned friends in the middle of the night?
  ☐ ☐
- You were much more interested in sex than usual?
  ☐ ☐
- You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?
  ☐ ☐
- Spending money got you or your family into trouble?
  ☐ ☐
- If you checked **YES** to more than one of the above have you experienced several of these during the same period of time?
  ☐ **YES** ☐ **NO**

- How much of a problem did any of these situations cause you (like being unable to work: having family, money, or legal problems: and/or getting into serious arguments or fights)?
  Please circle only one answer:

No Problem **Minor Problem** **Moderate Problem** **Serious Problem**

Over the last 2 weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things?

  (0) Not at all **(1) Several days** **(2) More than half the days** **(3) Nearly every day**

- Feeling down, depressed, or hopeless?

  (0) Not at all **(1) Several days** **(2) More than half the days** **(3) Nearly every day**

- Trouble falling or staying asleep, or sleeping to much?

  (0) Not at all **(1) Several days** **(2) More than half the days** **(3) Nearly every day**

- Feeling tired or having little energy?

  (0) Not at all **(1) Several days** **(2) More than half the days** **(3) Nearly every day**

- Poor appetite or overeating?

  (0) Not at all **(1) Several days** **(2) More than half the days** **(3) Nearly every day**

- Feeling bad about yourself – that you are a failure or have let yourself or your family down?

  (0) Not at all **(1) Several days** **(2) More than half the days** **(3) Nearly every day**

- Trouble concentrating on things, such as reading the newspaper or watching television?

  (0) Not at all **(1) Several days** **(2) More than half the days** **(3) Nearly every day**

- Moving or speaking so slowly that other people could have noticed?

  (0) Not at all **(1) Several days** **(2) More than half the days** **(3) Nearly every day**

- Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?

  (0) Not at all **(1) Several days** **(2) More than half the days** **(3) Nearly every day**

- Thoughts that you would be better off dead or hurting yourself in some way?

  (0) Not at all **(1) Several days** **(2) More than half the days** **(3) Nearly every day**

- If you have experienced any of these problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?
  Please circle only one answer:

  ☐ Not difficult at all ☐ somewhat difficult ☐ Very difficult ☐ extremely difficult

Additional questions regarding your mental health history:

- Have you ever suffered from a major depressive episode? (Sad mood, loss of interest and motivation lasting more than 2 weeks)

  YES_____ NO_____

- Have you ever experienced a Panic Attack? (A feeling of dread as if you were being chased by a tiger but there was no tiger chasing you)

  YES_____ NO_____

- Have you experienced any events in your lifetime, even as a child, that you consider to be traumatizing and you still think of on a regular basis or if under stress?

  YES_____ NO_____

- Do you have significant mood swings to the point that these moods have interfered with your daily functioning?

  YES_____ NO_____

- Do you experience symptoms, emotional and/or physical around the time of your menstrual period that interfere with your normal daily functioning?

  YES_____ NO_____

- Have you ever been diagnosed or do you feel you may be suffering from a specific Eating Disorder such as Anorexia Nervosa, Bulimia Nervosa or Binge Eating Disorder?

  YES_____ NO_____

- Have you ever been diagnosed or do you feel you may be suffering from ADHD (Attention Deficit Hyperactivity Disorder)?
  YES_____ NO_____

- Have you ever been on treatment, either medication or therapy for a mental health disorder?

  YES_____ NO_____

- Have you ever been addicted to drugs or alcohol?

  YES_____ NO_____

Current Medications

Please include all medications that you are currently taking including prescription medicines, over the counter (OTC) medicines, Birth Control Pills, Hormone Replacement Therapy, or Herbal Supplements. Please include the approximate date that you started the medication.

	Medication Name	Dosage (Mg)	Times Per Day	Start Date
1)				
2)				
3)				
4)				
5)				

If more space is required, please use page 13 of this document

Epworth Sleepiness Scale:

Patient Name: _____
Date: _____

Hhow likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? I would like for you to consider time this past week, including today. Even if you have not done some of these things during the past week, estimate how likely you would be to doze off or fall asleep in these situations. Use the following scale to choose the most appropriate number for each situation.

0 = would *never* doze
1 = *slight* chance of dozing
2 = *moderate* chance of dozing
3 = *high* chance of dozing

Situation	**Chance of Dozing**
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting, inactive in a public place (e.g. a theatre or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car, while stopped for a few minutes in traffic	_____
TOTAL	_____

Medication Reactions
Have you ever had an adverse side effect to a medication such as nausea, vomiting or feeling badly from a medication in any way?

YES___ **NO___**

If **YES**, please list the specific medications and the specific side effects you experienced

Medication	**Specific Reaction or Side Effect**
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____

Surgical History
Please list any and all surgical procedures you ever had in chronological order starting with your first surgical procedure:

DATE	**SURGICAL PROCEDURE**
1) Date:_____	_____
2) Date:_____	_____
3) Date:_____	_____
4) Date:_____	_____

Have you ever experienced any **complications from Anesthesia** during Surgery? **YES _____ NO _____**
Have you ever suffered any surgical or **post surgical complications**? **YES _____ NO _____**

Health Related Lifestyle Habits

Have you ever smoked cigarettes? **YES____ NO____** If **yes** how many did you smoke per day? _____

Have you quit smoking? **YES____ NO_____** When was your Quit date? _____

How many years have you smoked cigarettes? _____

Are you interested in medical help to quit smoking? **YES____ NO_____**

How many days per week do you drink alcohol? _____

Do you feel you have a drinking problem? **YES_____ NO_____**

If **YES**, are you interested in medical help to quit drinking alcohol? **YES_____ NO_____**

Do you use any recreational drugs? **YES_____ NO_____**

Do you feel you have a drug problem? **YES_____ NO_____**

If **YES**, are you interested in medical help to quit using recreational drugs? **YES_____ NO_____**

PHYSICAL ACTIVITY:

- Do you engage in any form of regular physical activity? (at least 3 days per week)
  YES _____ NO_____

NUTRITIONAL HABITS:

- Would you describe your current diet as healthy? **YES____ NO____**
- How long after you first wake up for the day do you eat something : _____ **(minutes)**
- Estimate how many grams of fiber you eat daily? _____ or if you have no idea, please circle
  Grams
  No Idea
- How many meals and snacks do you eat daily? ____ ____
  Meals Snacks

Weight History

- What is your Current Weight? _____ pounds
- Is your current weight the maximum weight you have ever been at? **YES_____ NO_____**
- If not, what was the maximum weight you have ever been at? _____ **Lbs.** *approx date:*
- What did you weigh prior to your first pregnancy before you were pregnant? _____ Lbs.
- To the best of your recollection, please list your weight (in pounds) at the following milestones:
  Age 10____ Age 18____ Age 30____ Age 40____ Age 50 ____ Age 60____
- Are there any immediate family members (mother, father sisters, brothers, and children) that are significantly overweight or obese? **YES_____ NO_____**
- In general, do you have a difficult time feeling full or satisfied when you eat? **YES_____ NO_____**
- Do you think about food or "obsess" about food on a regular basis? **YES_____ NO_____**
- Is there a specific time of day at which your appetite is most difficult to control? **YES_____ NO_____**
  If your answer was Yes, please indicate which time of day is most difficult:
  Morning_____ Mid-day _____ Evening____ Bed time____ Middle of the night_____
- Do you ever "binge" eat? (eat a large quantity of food very rapidly and then feel remorse or feel angry at yourself) **YES_____ NO_____**
- Have you ever binged and then purged what you ate (induce vomiting)? **YES_____ NO_____**
- Have you ever taken diuretics or laxatives as a means of losing weight? **YES _____ NO_____**
- Have you ever taken any **weight loss medications** either prescribed by a physician or over the counter?
  YES_____ NO_____

If your answer was **YES**, please list the weight loss medications that you have taken, the length of time that you took them and the reason for discontinuing the medication:

	Name of the Medication	Time on Med (weeks)	Reason for Discounting
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Previous weight loss efforts and current weight-loss goals

- In your lifetime approximate the number of times you have been on a diet. (By "diet", I am referring to any period of time
  you consciously were following some specific program designed to reduce your calorie intake in some way.)_____
- What was the most successful "diet" you have ever followed in terms of the most weight lost?

  ☐ Weight Watchers ☐ Jenny Craig ☐ Atkins ☐ South Beach ☐ Liqui

  ☐ Other_____
- How much weight did you lose on this diet? _____ Pounds
- What was your weight when you began this diet? _____ Pounds
- What was the lowest weight you attained on this diet? _____ Pounds
- For how long (in months) were you able to maintain this weight loss? _____Months
- Regarding your weight loss expectations; at the end of 1 year in a medical weight loss program what is:

  Your realistic goal weight in _____ Pounds
- What is the minimal amount of weight you can lose after one year and still be pleased with the outcome of a weight loss program _____ Pounds?
- What is the amount of weight loss after one year that you would consider to be disappointing?

  _____**Lbs**

If there is anything that is of concern to you that was not covered in this Intake Form, please feel free to make a note of it and we can address it at the time of our face to face meeting: