Amy Johnson, RD, CDE
Registered Dietitian

ARTHRITIS & SPORTS
Orthopaedics • Physical Therapy • Wellness

Health Assessment Patient Questionnaire

Please bring in the following information for your first nutrition appointment:

- List of medication and any vitamins/supplements you take
- Copy of most recent blood work
- Blood sugar log/meter (if you have diabetes)

One's health and well-being are influenced by many different things, including lifestyle, family history, emotional health, and nutrition/eating habits. Please complete the following questionnaire to the best of your ability to give us an overall view of your general lifestyle and health habits.

First Name: _____ Last Name: _____

DOB: _____ SSN: _____ Height: _____ Weight: _____

Gender: _____ How do you rate your health **(please check one)?** ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Have you been treated by Arthritis & Sports during this current year **(please check one)?** ☐ Y ☐ N

Are you a self-pay patient **(please check one)?** ☐ Y ☐ N

If you answered "yes" to either question, you can skip the rest of page 1 and go onto page 2

If you answered "no" to both questions, please fill in the rest of page 1 before proceeding

Background Information

Address: _____ Marital Status: _____

City: _____ State: _____ Zip: _____ Sex: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

General Health Information

Physician's name: _____ Physician's phone: _____

Physician's address: _____ State: _____ Zip: _____

Insurance

Primary Insurance: _____ Policy Eff Date: _____

Subscriber: _____ Subscriber DOB: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy Eff Date: _____

Subscriber: _____ Subscriber DOB: _____

Policy #: _____ Group #: _____

Emergency Contact: _____ Phone Number: _____

I certify that all the information provided herein is true and correct.

Patient/Guardian Signature: _____ Date: _____

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Review of Systems **(check all that you currently have or are concerned about)**

Respiratory

- ☐ Shortness of breath
- ☐ Coughing
- ☐ Asthma or wheezing
- ☐ Emphysema
- ☐ Snoring
- ☐ Daytime sleepiness
- ☐ Disturbed sleep
- ☐ Sleep apnea
- ☐ History of pneumonia, chronic bronchitis, or COPD

Cardiovascular

- ☐ High blood pressure
- ☐ Heart disease/heart attack
- ☐ Congestive heart failure
- ☐ Heart murmur
- ☐ Irregular heartbeat or palpitations
- ☐ Chest pain or discomfort
- ☐ Ankle or feet swelling
- ☐ Varicose veins
- ☐ Blood clots or clotting disorders

Gastrointestinal

- ☐ Nausea/vomiting
- ☐ Abdominal/stomach pain
- ☐ Heartburn/acid reflux
- ☐ Belching/burping
- ☐ Ulcer disease
- ☐ Rectal bleeding or blood in stools
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gallbladder disease/gallstones
- ☐ Celiac disease
- ☐ Hernia

Genitourinary

- ☐ Difficulty urinating
- ☐ Urinary incontinence (leaking urine)
- ☐ Inability to empty bladder fully
- ☐ Recurrent urinary tract infections
- ☐ Infertility
- ☐ Sexual problems
- ☐ Abnormal menstrual periods
- ☐ Enlarged prostate

Musculoskeletal

- ☐ Aching muscles or joints
- ☐ Lower back pain/disc problems
- ☐ Arthritis

Endocrine

- ☐ Diabetes mellitus
- ☐ High cholesterol
- ☐ Thyroid disease
- ☐ Gout
- ☐ High triglycerides

Skin and Hair

- ☐ Skin sores or infections (boils, ulcers, skin fold irritations)
- ☐ Bruises easily
- ☐ Chronic rashes or dermatitis or eczema Excessive facial/ body hair (women only)

Other

- ☐ Low energy level
- ☐ Depression
- ☐ Bipolar disorder
- ☐ Obsessive-compulsive disorder (OCD)
- ☐ Psychological or psychiatric care
- ☐ Headaches or migraines
- ☐ Anxiety disorder or panic attacks
- ☐ Binge eating
- ☐ Bulimia
- ☐ Anorexia
- ☐ Anemia
- ☐ History of any physical or verbal abuse
- ☐ Attention deficit disorder (ADD) or attention deficit and hyperactivity disorder (ADHD)

Cancer (list type): _____

Other serious medical conditions (list types): _____

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Do you have a family history of any of the following? **(check all that apply)**

☐ High blood pressure ☐ High blood cholesterol ☐ Diabetes ☐ Thyroid disease
☐ Obesity ☐ Heart disease ☐ Cancer

Other (list): _____

List the types of surgeries you have had: _____

_____

How often do you use tobacco? _____ How often do you drink alcohol? _____

How many hours of sleep do you average per night? _____ Is your sleep restful **(circle one)? Y N**

On a scale from 1 (low stress) to 5 (high stress), how would you rate your daily stress level **(circle one)?**

1 2 3 4 5

How do you cope with stress in your daily life? _____

_____

Please list any religious practices that affect your health care or diet:

_____

List all prescription and over-the-counter medications that you currently take (include the dosages):

_____

_____

_____

List all vitamins, minerals, supplements, and herbs that you take:

_____

_____

On a scale of 1 (not ready) to 5 (very ready), how ready are you to make lifestyle changes **(circle one)?**

1 2 3 4 5

On a scale of 1 (not at all confident) to 5 (very confident), how confident are you to make lifestyle changes **(circle one)?**

1 2 3 4 5

What makes it hard for you to lose weight and keep it off? _____

_____

_____

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Nutrition Information

Please list any food allergies: _____

Are you a vegetarian/vegan **(circle one)? Y N**

How often do you eat out/take out? _____ times per week

How many alcoholic drinks do you consume per day? _____

What type (including mixers): _____

What one or two things would you like to change about your diet? _____

_____

Describe when and what you usually eat and drink in a typical day. (Write "None" if you do not eat that meal or snack.)

Meal	**Time**	**Foods Eaten/Amount**
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

Physical Activity Information

Are you currently receiving Physical Therapy **(circle one)? Y N**

What is the most physically active thing you do in an average day? _____

_____

What, if any, regular exercises do you do? How often and for how long do you participate? _____

_____

Do you know of any reason(s) why you should not do physical activity? If yes, please explain the reasons.

_____

_____

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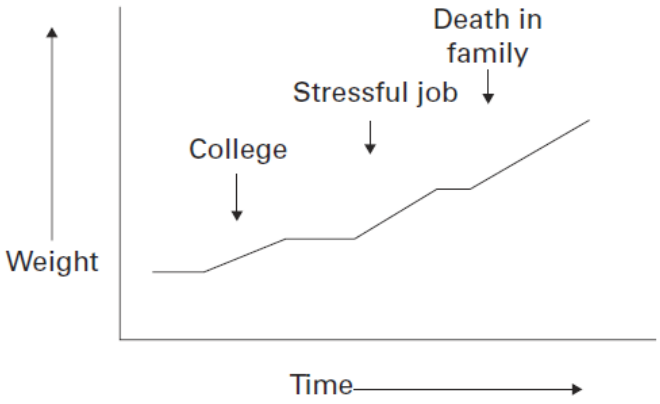
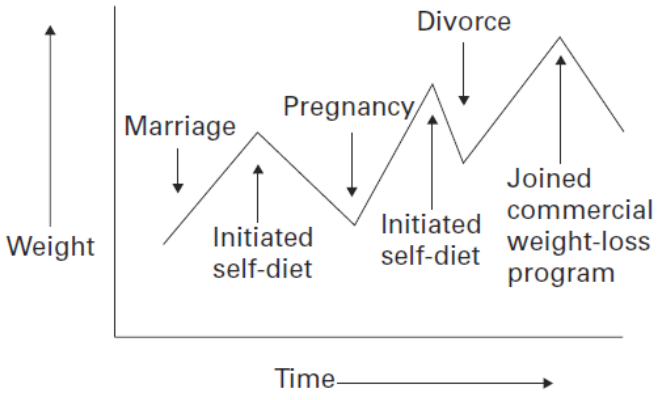
Weight History Graph

Most people can relate changes in their weight to different life events. The following graphs illustrate two examples of how people have gained weight.

Progressive (or Ratcheting) Weight Gain



Weight Cycling or "Yo-Yo" Weight Gain



Please draw a graph of your weight gain. Mark life events and diet attempts that have contributed to your current weight.