In/Sight Stress Reduction
HEALTH AND LIFESTYLE ASSESSMENT

Name____Today's Date____________

Date of Birth:______________________ Age:__________ Gender: M F

Phone:___________________________ Email:_____________________________________

Address:____

Referred by:_______________________________ Interviewer: Gertler Krantz

PRESENT HEALTH STATUS

1. In general, please rate your overall health: (please circle a number)
   0 1 2 3 4 5 6 7 8 9 10
   unhealthy/ill very healthy

2. What physical symptoms have prompted your interest in this program?
   ____
   ____
   ____
   In the past year, how many times have you met with a physician for treatment of these symptoms? ____

3. What emotional symptoms have prompted your interest in this program?
   ____
   ____
   ____
   List any treatment you have had for any of these symptoms:____________
   ____
   ____

4. List any <u>currently</u> prescribed medications and the condition for which it is prescribed:

Medications:	*Condition:*
____________________________	_________________________________
____________________________	_________________________________
____________________________	_________________________________
____________________________	_________________________________

5. List any drug or food allergies: ____
   ____

6. List any over-the-counter medications or dietary supplements you are currently taking: ____
____

7. List any lab work, x-rays, or consultations with specialists related to your primary symptoms (include approximate dates): ______________________
____
____

8. Family History:

	Age (if deceased, age of death/cause)	*Medical/ Psychological illnesses*
Mother:	____________________________	____________________________
Father:	____________________________	____________________________
Brother(s):	____________________________	____________________________
	____________________________	____________________________
Sister(s):	____________________________	____________________________
	____________________________	____________________________

PAST HEALTH STATUS

1. Have you ever had any of the following? (please check all that apply)

____arthritis	____injuries to back, arms, legs
____dizziness, fainting	____sleeping disorder
____seizures	____thyroid problems
____anemia	____stroke
____anxiety/depression	____hypertension
____asthma	____cholesterol problems (last level _____)
____cancer	____heart disease
____gastrointestinal disorder	

2. Please describe your medical history (major illnesses, accidents, injuries):
____
____
____

3. Surgical procedures (include dates): ________________________________
____
____

4. Hospitalizations (include dates): ___________________________________
____
____

5. Have you ever sought counseling to help you cope? ____Yes ____No
   If yes, what type of counselor did you see (psychiatrist, psychologist, clinical social worker, counselor, other):___________________________
   When? ____

6. Are you currently seeing a therapist? ____Yes ____No
   If yes, what type? ____________________________ For how long?________________
   How often do you meet? ___________________

7. Have you found counseling and/or therapy helpful? (Circle number.)

1	**2**	**3**	**4**	**5**
not at all				very helpful

8. Current therapist: ______________________________ Phone: _____________________

9. Current primary care physician: ____
   Phone: ____________________________________
   Date of last physical exam: _______________

HEALTH HABITS

1. Do you smoke cigarettes? ____Yes ____No
   If yes, how many per day? _______ For how many years? ___________
   If no, did you ever smoke? ____Yes ____No
   For how long? ____________ Date of last cigarette: ___________________

2. If you drink alcohol at least once per month, please estimate how much:
   Wine (glasses/week) _____________ Beer (glasses/week) _______________
   Other alcohol (ounces/week) ____________________________
   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 get rid of a hangover? ____Yes ____No

3. Do you use recreational drugs? ____Yes ____No
   If yes, please indicate type(s):____

NUTRITION

1. Do you consider yourself: ____overweight? ____underweight? ____about right?
   What is your ideal weight?______ Has your weight changed recently? ________
   Have you ever seen a dietician for nutrition counseling? ____Yes ____No
   If yes, where and when? ____

2. Do any of the factors listed below make it difficult for you to eat right? (check all that apply)
   ____eating out
   ____taking large portions
   ____frequent snacking
   ____I need information on healthful eating
   ____dislike recommended foods
   ____moods
   ____someone else cooks

3. Do you eat at least two fruits and vegetables each day? ____Yes ____No

4. Are you on a special diet? (please describe) ____
____
5. Do you drink caffeinated beverages? ___Yes ___No
   What type(s) and amounts per day? ____

ACTIVITY/EXERCISE

1. How active are you? ____ very ____ moderately ____ sedentary
2. Do you have any physical problems that limit your activity? ___Yes ___No
   If yes, please describe:____
3. If you exercise on a regular basis, please complete:

Activity (e.g. walking, biking, swimming)	*Frequency*
____________________	__________
____________________	__________
____________________	__________
____________________	__________

4. If you are not engaged in a routine exercise program, what type of exercise would you most like to do? ____
5. What are your goals for exercise? ____

SLEEP/REST

1. Number of hours of sleep per night: ____ Do you nap? ____ Duration: ____
2. Do you feel rested upon awakening? ___Yes ___No
3. Problems with insomnia? ___Yes ___No
   If yes, what kind of problems? ____
4. Do you use sleeping aids? ___Yes ___No
   If yes, specify type and frequency: ____

COGNITIVE/PERCEPTUAL

1. Do you have a significant hearing difficulty? ___Yes ___No
2. Do you have a significant visual problem? ___Yes ___No
3. Do you have significant learning difficulties? ___Yes ___No

SELF-PERCEPTION/SELF CONCEPT

1. On a scale of 0 to 10, please rate your general sense of self-confidence:
   0 1 2 3 4 5 6 7 8 9 10
   not confident very confident

2. Please describe yourself: ____
____
____
____

3. List three things you like about yourself: ______________________________________
____
____
____

4. List three things you would like to change about yourself: ___________________
____
____
____

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

____fear	____anxiety	____isolation
____guilt	____shame	____lack of control
____helplessness	____hopelessness	____hostility
____sadness	____anger	____depression

ROLES/RELATIONSHIPS

1. Marital status (check one): _
   ___married ____single ____living in a committed relationship
   ____divorced ____separated ____widowed

2. Number of children: _____ Ages: __________________ How many at home? _____
3. How many people live in your household? _____
4. Your occupation: ______________________________ Hours worked per week: _____
5. Education level completed: (circle highest completed grade)

Grade school	High school	College	Graduate
1 2 3 4 5 6 7 8	9 10 11 12	13 14 15 16	17 18 19 20+

6. Social Roles (please check all that apply to you):
   ____friend ____parent ____employer ____employee ____spouse
   ____child ____caretaker ____community volunteer ____other(list)________

7. What resources do you have for emotional support? (check all that apply)
   ____spouse ____family ____friends ____religion/spiritual
   ____pets ____other (specify)_________________________________

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 that may interfere with your life? (Please circle number corresponding to each, with 1 being no stress and 10 being 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**
Living Situation:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Neighborhood:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Other:	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

please specify____

3. Have you ever been abused, a victim of a crime, or experienced trauma?
   ____Yes ____No
4. What attitudes, assumptions, and beliefs help you cope when life becomes stressful? ____
   ____
5. Do you meditate or practice a relaxation technique? ____Yes ____No
   If yes, check all that apply:
   ____yoga ____imagery ____abdominal breathing ____meditation
   ____Tai Chi ____prayer ____progressive muscle relaxation ____other

What is your motivation for enrolling in the Stress Reduction Program? ____________
____
____

What goals do you hope to achieve during this program? ____________________
____
____

Other comments: