Health Risk Assessment Form

General

Name: ______________________
DOB: ____________ Gender: ____________
Height: ____________ Weight: ____________
Race: ______________________

Medical History

Date of last check-up: ______________________
Allergies: ______________________
Medications: ______________________
Previous Medications: ______________________
Injuries: ______________________
Surgeries: ______________________
Blood Pressure: ______________________
Cholesterol: ______________________

History of…

Cancer: ❑ Me ❑ Relation: ____________
Diabetes: ❑ Me ❑ Relation: ____________
Stroke: ❑ Me ❑ Relation: ____________
Heart Disease: ❑ Me ❑ Relation: ____________
Heart Attack: ❑ Me ❑ Relation: ____________
Depression: ❑ Me ❑ Relation: ____________
Bipolar Disorder: ❑ Me ❑ Relation: ____________

Females

Last date of most recent cycle: ____________
Date of last PAP Smear: ____________
Date of last breast exam: ____________
Date of last rectal exam: ____________
Year of last pregnancy: ____________
Did the pregnancy come to term? ❑ Yes ❑ No

Males

Date of last prostate exam: ____________

Well-Being

Rate your overall well-being: ❑ Great ❑ Good ❑ Fair ❑ Poor ❑ Bad

Rate your health: ❑ Great ❑ Good ❑ Fair ❑ Poor ❑ Bad

How safe do you feel? ❑ Very ❑ Not Very ❑ Not at all

How satisfied are you with your life? ❑ Very ❑ Not Very ❑ Not at all

How often do you feel depressed? ❑ Always ❑ Often ❑ Occasionally ❑ Never

Current therapist: ____________
Frequency of sessions: ____________
Starting date: ____________

Nutrition

How many daily servings of vegetables do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of fruit do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of grains do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of meat do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of sugar/carbs do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

Drug Use

How often do you smoke tobacco? ❑ Never ❑ Occasionally ❑ Often ❑ Daily ❑ Used to
How often do you chew tobacco? ❑ Never ❑ Occasionally ❑ Often ❑ Daily ❑ Used to
When did the tobacco use start? ____________
How many cigarettes do you have per day? ____________

How many alcoholic drinks do you have per week? ____________
How often do you binge drink (5+ drinks in 1 hour)? ❑ Occasionally ❑ Weekly ❑ Daily ❑ Never
Have you ever been treated for alcoholism? ____________
How often do you black out/lose time? ____________

Have you ever used recreational drugs? ____________
Which drugs? ____________
Have you ever abused prescription drugs? ____________
Which drugs? ____________
Have you ever been treated for drug use? ____________
How often do you use recreational drugs? ❑ Daily ❑ Weekly ❑ Often ❑ Occasionally ❑ Rarely ❑ Never

Exercise

How many days per week do you work on cardio? ____________
Length of time spent on cardio each session: ____________
How many days per week do you work on strength? ____________
Length of time spent on strength each session: ____________
Injuries/conditions that interfere with exercise: ____________

Other

Volunteer Activities: ____________
Who do you live with? ____________
Do you require…? ❑ Hearing Aid ❑ Walker ❑ Cane ❑ Oxygen Tank ❑ Glasses
How often do you get headaches? ____________
Food Sensitivities: ____________
How many hours of sleep do you get per night? ____________
How restful is your sleep? ❑ Restful ❑ I wake up once or twice ❑ I wake up often ❑ Fitful

Social Wellness Assessment

	Yes/Almost Always	Very Often	Sometimes	Occasionally	No/Almost Never
I have at least one person in whom I can confide	10	7	5	3	1
I have a good relationship with my family	10	7	5	3	1
I have friends at work or school from whom I gain support and with whom I talk regularly	10	7	5	3	1
I am involved in school activities	10	7	5	3	1
I am involved in my community	10	7	5	3	1
I do something for fun and just for myself at least once a week	10	7	5	3	1
I am able to develop close, intimate relation-ships	10	7	5	3	1
I engage in activities that contribute to the en-vironment am interested in the views, opinions, activities, and accomplishments of others	10	7	5	3	1
I am interested in the views, opinions, activities, and accomplishments of others	10	7	5	3	1
I provide social support to others	10	7	5	3	1

score__________

Source: Anspaugh, David J., Hamrick, Michael H., Rosato, Frank D.
Wellness Concepts and Applications (2015) McGraw-Hill, NY, New York

Spiritual Wellness Assessment

	Yes/Almost Always	Very Often	Sometimes	Occasionally	No/Almost Never
I know my values and beliefs	10	7	5	3	1
I live by my convictions	10	7	5	3	1
My life has meaning and direction	10	7	5	3	1
I derive strength from my spiritual life each day	10	7	5	3	1
I have life goals that I strive to hit each day	10	7	5	3	1
I view life as a learning experience and look forward to the future	10	7	5	3	1
I have a sense of peace about my life	10	7	5	3	1
I am tolerant of the values and beliefs of others	10	7	5	3	1
I'm satisfied with the degree to which my activities are consistent with my values	10	7	5	3	1
Personal reflection is an important part of my life	10	7	5	3	1

score__________

Source: Anspaugh, David J., Hamrick, Michael H., Rosato, Frank D.
Wellness Concepts and Applications (2015) McGraw-Hill, NY, New York

Emotional Wellness Assessment

	Yes/Almost Always	Very Often	Sometimes	Occasionally	No/Almost Never
I feel positive about myself and my life	10	7	5	3	1
I am able to be the person I choose to be	10	7	5	3	1
I am satisfied that I'm doing to the best of my abilities	10	7	5	3	1
I can cope with life's ups and downs effectively in a healthy manner	10	7	5	3	1
I am not judgmental in my approach to others	10	7	5	3	1
I feel there is an appropriate amount of excitement in my life	10	7	5	3	1
When I make mistakes, I learn from them	10	7	5	3	1
I can say no without feeling guilty	10	7	5	3	1
I find it easy to laugh	10	7	5	3	1
I avoid blaming others for my failures or problems	10	7	5	3	1

score__________

Source: Anspaugh, David J., Hamrick, Michael H., Rosato, Frank D.
Wellness Concepts and Applications (2015) McGraw-Hill, NY, New York

Stress Control Assessment

	Yes/Almost Always	Very Often	Sometimes	Occasionally	No/Almost Never
I am easily distracted	10	7	5	3	1
I tend to be nervous	10	7	5	3	1
I prepare ahead of time for events or situations that cause stress	10	7	5	3	1
I schedule enough time to accomplish what needs to be done	10	7	5	3	1
I set realistic goals for myself	10	7	5	3	1
I can express my feelings of anger	10	7	5	3	1
I avoid putting off important tasks to the last minute	10	7	5	3	1
I participate in activities that provide relief from stress	10	7	5	3	1
When working under pressure, I can stay calm and patient	10	7	5	3	1
I can make decisions with a minimum of stress and worry	10	7	5	3	1

score__________

Source: Anspaugh, David J., Hamrick, Michael H., Rosato, Frank D.
Wellness Concepts and Applications (2015) McGraw-Hill, NY, New York