BERMUDA BWOC WELLNESS AND OUTREACH CENTRE

3 Gorham Road, Pembroke HM08 Bermuda (P) 292-4530 (F) 295-1279

Health and Lifestyle Questionnaire

NAME: _____ **D.O.B**_____

Doctors Name: _____ **Phone #**_____

CONFIDENTIAL HEALTH QUESTIONNAIRE

HAVE YOU OR DO YOU SUFFER FROM ANY OF THE FOLLOWING.
(Please tick & give details where applicable)

Asthma	Diabetes	Rheumatic Fever
Angina	Frequent Colds	High Cholesterol
High Blood Pressure	Dizziness/fainting	Palpitations
Low Blood Pressure	Heart Disease	Headaches
Epilepsy	Shortness of breath	Migraines
Arthritis	Constipation	Joint Pain

DETAILS:

_____

_____

_____

Additional Problems (Any health condition not listed above)

_____

_____

_____

_____

Inactive Problems (Problem you once had in the past but are now resolved)

_____

_____

Medications & herbs (Include how much you take and how frequently you take them)

_____

_____

_____

Allergies (List all allergies)

_____
_____
_____

Tobacco (Frequency of use)

_____
_____

Alcohol (Frequency of use)

_____
_____

Interventions (For any health conditions)

_____
_____

Social History (Marriage, children etc.)

_____
_____

Have any of your first-degree relatives experienced the following conditions? If Yes Please circle.

Heart attack Heart operation Congenital heart disease High cholesterol

Have you ever had surgery? Yes No
If yes give details.

_____

Have you ever broken any bones? Yes No
If yes give details.

_____

Do you suffer from back pain? Yes No
If yes give details.

_____

Do you experience stiff, swollen or painful joints? Yes No
If yes give details.

_____

What is your "chief complaint"?

_____

Date of onset & duration

_____

What incident do you feel may have caused the problem?

_____

Treatment to date

_____

Previous diagnoses

_____

Does your "chief complaint" affect you on a day-to-day basis? Yes No
If yes give details

_____

Are the symptoms brought on by certain activities? Yes No
If yes give details

_____

Do specific activities or positions alleviate your symptoms? Yes No
If yes give details

_____

When is the pain worse?

_____

Do you experience fatigue or lack of energy? If yes provide details.

_____

LIFESTYLE QUESTIONNAIRE

How much time do you spend in a seated position?

_____

On a scale of 1 to 10 (1=not active, 10=very active) please rate how active you are on a daily basis?

_____

Are you currently involved in any exercise program? If yes please list how long and what type of exercises.

_____

_____

Do you smoke? Yes No If yes, how many per day

_____

Do you follow, or have you recently followed, any specific dietary intake plan, and in general how do you feel about your nutritional habits?

_____

_____

GOAL QUESTIONNAIRE

Please list THREE goals in order of importance:

1. _____

2. _____

3. _____

Where are you now in relation to your goals?

_____

How much time are you willing to devote toward achieving this goal?

_____

What is the biggest challenge you must overcome in attaining your goal?

_____

On a scale of 1 to 10 (1=not committed, 10=very committed), please rate how committed you are to achieving your goals?

_____

List three tasks you can do daily, which will help pave the path toward total achievement?

1. _____

2. _____

3. _____

All information on this form is correct to the best of my knowledge and I have sought, and followed, any necessary medical advice.

Client's Signature: _____ Date: _____