# WELLNESS ASSESSMENT FORM

| **Name** | | | | | | **Date** |
|---|---|---|---|---|---|---|
| **Birth Information** | | | | | | |
| Date of birth | | Place of birth | | | | Age |
| **Ethnic Background** | | | | | | |
| Caucasian | ❑ | African American | ❑ | Asian American | ❑ | |
| Hispanic | ❑ | Native American | ❑ | Other | ❑ | |
| **Gender** | | **Marital Status** | | | | |
| Female | ❑ | Never married | ❑ | Widow/widower | ❑ | |
| Male | ❑ | Married | ❑ | Separated/Divorced | ❑ | |
| **Education** | | | | | | |
| High school (circle one) | | College/university (circle one) | | Graduate school (circle one) | | |
| 6th or earlier 7th 8th | | 1 2 3 4 | | BA BS MA MS | | |
| 9th 10th 11th 12th | | 5 Other | | MBA Other | | |
| **Occupation** | | | | | | |
| | | | | | | |

## Chief Complaint

❑ DEPRESSION ❑ ANXIETY ❑ ATTENTION ❑ MEMORY

❑ FATIGUE ❑ BURNOUT ❑ ____________________ ❑ ____________________

________________________________________________________________________

________________________________________________________________________

| **MEDICATION HISTORY (including herbal preparations and vitamins)** | | | | | **RESPONSE** | | |
|---|---|---|---|---|---|---|---|
| **MEDICATION** | **DOSE** | **Freq** | **Start** | **Stop** | **None** | **Good** | **Excel** |
| 1 | | | | | ❑ | ❑ | ❑ |
| 2 | | | | | ❑ | ❑ | ❑ |
| 3 | | | | | ❑ | ❑ | ❑ |
| 4 | | | | | ❑ | ❑ | ❑ |
| 5 | | | | | ❑ | ❑ | ❑ |
| 6 | | | | | ❑ | ❑ | ❑ |
| 7 | | | | | ❑ | ❑ | ❑ |
| 8 | | | | | ❑ | ❑ | ❑ |

## Past Medical History:

**Neurological**: Head Injury, Parkinson's disease, Stroke, Seizure,
**Cardiac**: Hypertension, Heart Attack, Angina, CHF, Arrhythmias
**Respiratory**: Asthma, Emphysema, COPD
**Endocrine:** Thyroid disease, Diabetes
**Cancer:** Melanoma, Lung, Breast, Prostate
**GI:** Ulcer, Liver
**Psychiatric:** Anxiety, Depression, Bipolar, PTSD, OCD
**Blood**: Anemia, Leukemia, Bleeding disorder, Anticoagulant

| CONDITION | DATES | COMMENTS | Stable |
|---|---|---|---|
| | | | ❑ |
| | | | ❑ |
| | | | ❑ |
| | | | ❑ |
| | | | ❑ |

| FAMILY HISTORY | CONDITION |
|---|---|
| Father/ Mother/Siblings | |
| | |
| | |
| | |

**ALLERGIES** None ❑

| Substance | Reaction |
|---|---|
| | |
| | |
| | |

**REVIEW OF SYSTEMS**

1. General (Weight change, fever, fatigue) ❑
2. Neurological (Headache, dizziness, weakness) ❑
3. Head and neck (Hearing loss/aid, visual difficulties) ❑
4. Respiratory (Shortness of breath, cough, wheezing) ❑
5. Cardiovascular (Chest pain, palpitations) ❑
6. Gastrointestinal (Nausea, constipation, diarrhea) ❑
7. Extremities (Claudication, edema, muscle cramps) ❑
8. Gait and joints (Arthritis, pain, falls, devices) ❑
9. Skin (Rashes, itching, swelling) ❑
10. Genitourinary (Urinary frequency, incontinence) ❑
11. GYN (Irregular menses, painful menses) ❑

Comments (Use number to identify question.)

**SMOKING** Never ❑

Packs per day: 1 ❑ 2 ❑ 3 ❑ Other ❑
Age began: years old ❑ Quit: years old

**ALCOHOL USE** ❑

**CAGE**

1. Average daily consumption (ounces)
   1 ❑ 2 ❑ 3 ❑ 4 ❑ .
2. Ever told or felt you should **c**ut down on ❑
3. Ever felt bad or **g**uilty about your drinking? ❑
4. Ever drink first thing in AM to get rid of ❑

| DRUGS OF ABUSE None ❑ |
|---|
| 1. Marijuana |
| 2. Cocaine/crack |
| 3. Other |
| **MENSTRUAL/PREGNANCY HISTORY** |
| 4. Menopause age _________ |
| 5. Last menstrual period date ______ / ______ / _____ |
| 6. Gravida ______ Para ______ Abortion(s) ______ |

Contraceptive Method:

| BIOMETRICS | FASTING BLOOD | DRAWING | |
|---|---|---|---|
| 1. HEIGHT | 5. CBC | 9. TSH | HBA1c if needed |
| 2. WEIGHT | 6. CMP | 10. LIPID PANEL | IRON if needed |
| 3. BP / | 7. ESR | 11. VITAMIN B12 | Waist Measure |
| 4. PR | 8. CRP | 12. VITAMIN D – 25OH D3 | Hip Measure |

| DIAGNOSTIC IMPRESSION (Check appropriate diagnosis) | |
|---|---|
| **1.** | ❑ |
| **2.** | ❑ |
| **3.** | ❑ |
| **4.** | ❑ |
| **5.** | ❑ |

| SUMMARY AND PLAN | |
|---|---|
| **1. Evaluation & Counseling: LIVE WITH LOVE** | ❑ |
| **2. LIFESTYLE** | ❑ |
| **A. NUTRITION:** | ❑ |
| **B. EXERCISE:** | ❑ |
| **C. RELAXATION:** | ❑ |
| **D. SLEEP:** | ❑ |
| **3. ORGANIZATIONAL SKILLS:** | ❑ |
| **4. VALUES:** | ❑ |
| **5. ENJOY:** | ❑ |
| | **/ / 20** |
| **GABRIELA CORA, MD, DFAPA, MHA, MBA** | **DATE** |