**Sunshine**

**Behavioral Medicine**

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Adult and Geriatric Medical Services

FREE

*Mental and Physical Health*

*Self-Assessment*

This questionnaire does not intend to diagnose or treat any conditions. It serves only as a measure for the individual answering the questionnaire to become aware of possible symptoms indicating the need to seek medical attention.

Name: -------------------------------Date: ---------------------------------

**All affirmative (yes) answers are considered important and suggestive of the need for medical attention and care.**

Health History:

***Check the proper box if you were diagnosed and or treated for any of the following neurological disease:***

[\_\_] [Amyotrophic lateral sclerosis (ALS)](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/als.aspx)

[\_\_] Alzheimer’s disease [\_\_] [Aneurysm](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/aneurysm/) [\_\_] Back pain

[\_\_] Bell’s palsy [\_\_] Brain injury [\_\_] Fibromyalgia

[\_\_] Birth defects of the brain and spinal cord [\_\_] [Brain tumor](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/brain-tumor-center/)

[\_\_] Cerebral palsy [\_\_] Chronic fatigue syndrome [\_\_] [Concussion](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/headache-and-concussion/default.aspx)

[\_\_] Dementia [\_\_] Disk disease of neck and or lower back

[\_\_] Dizziness [\_\_] [Epilepsy](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/epilepsy/default.aspx) [\_\_] Guillain-Barre syndrome

[\_\_] [Headaches and migraines](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/migraine-headache/) [\_\_] [Multiple sclerosis](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/multiple-sclerosis.aspx)

[\_\_] Muscular dystrophy [\_\_] Neuralgia [\_\_] Neuropathy

[\_\_] Neuromuscular and related diseases [\_\_] [Parkinson’s disease](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/parkinsons-disease.aspx)

[\_\_] Scoliosis [\_\_] [Seizures](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/epilepsy/?gclid=Cj0KCQiAmuHhBRD0ARIsAFWyPwisLUjbNV2yKSXIqzwVKXG9aIrfuRxb8n66cLP2ZZ_maKrrcWT9taUaAkz5EALw_wcB) [\_\_] [Spinal cord injury](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/spine-surgery.aspx)

[\_\_] Spinal deformity and disorders [\_\_] Chronic Fatigue Disorder

[\_\_] Spine tumor [\_\_] [Stroke](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/stroke.aspx) [\_\_] Vertigo [\_\_] Dizziness

Fitness:

What are your measurements?

Height \_\_\_\_\_\_\_\_\_\_\_\_Weight \_\_\_\_\_\_\_\_\_BMI (Basal Metabolic Index) \_\_\_\_\_\_\_\_\_\_, [\_\_] I don’t know

What is your Ideal *(normal)* Body Weight (IBW) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [\_\_] I Do not know?

Answer each of these questions as honestly as you can. If you don't know the correct answer, just make a (best guess) or choose the closest answer. Mark down your answer to each of the questions (a, b, c or d) then once you have completed all the questions see the marking key below to get your measure of fitness.

***1. How would you describe your body weight?***

1. Obese (5)
2. Very overweight (10)
3. Slightly overweight (15)
4. Healthy weight range (20)

***2. How many days a week do you do some form of exercise?***

1. None (5)
2. 1 or 2 days (10)
3. 3 to 5 days (15)
4. 6 or more (20)

***3. Can you touch your toes?***

1. Not even close (5)
2. Nearly (10)
3. Just (15)
4. Easily (20)

***4. Could you walk along a straight line, like the "Walk and Turn" field sobriety test?***

1. Fail miserably (5)
2. I would step off the line a few times (10)
3. I might wobble a bit, but I'd make it (15)
4. No problem, give me a drink! (20)

***5. If you went out for a jog, how far do you think you could go before you had to stop for a rest?***

1. I wouldn't make it to the mailbox (5)
2. To the end of the block (10)
3. About a kilometer or mile (15)
4. A long way (20)

***6. How many push-ups do you think you could do?***

1. None (5)
2. A few (10)
3. Many (15)
4. Heaps (20)

***7. How would you go if you had to move some HEAVY furniture around the house?***

1. I'd be no help (5)
2. I'd pitch in but need a few helpers (10)
3. I could carry one end of it myself (15)
4. I could possibly do it myself (20)

***8. What could you jump over?***

1. Nothing (5)
2. A shoe box (10)
3. A low fence (15)
4. A high hurdle (20)

***9. If you had your purse/wallet stolen, would you be able to chase down the robber?***

1. No way (5)
2. I'd give it a go but probably not (10)
3. I could catch the thief but possibly not overpower them (15)
4. Easily (20)

***10. Confronted with a flight of stairs, would you ...?***

1. Choose the lift every time (5)
2. Walk up, but be out of breath (10)
3. Stride up, but still be out of breath (15)
4. Race up several flights no problem (20)

***Marking Key***

To get your Fitness Quotient score, give yourself the following points for each answer, and add up the total to get your Fitness Quotient.

|  |  |
| --- | --- |
| **Fitness Quotient** | **Rating** |
| < 70 | very poor |
| 70 - 100 | below average |
| 101 - 130 | average |
| 131 - 170 | above average |
| > 170 | excellent |

Is your fitness poor? [\_\_] Yes [\_\_] No

Is your fitness Below Average? [\_\_] Yes [\_\_] No

**Vegetative functions:**

Do you have any ***troubles*** with any of the following functions?

Appetite: [\_\_] Yes, [\_\_] No

Sleep: [\_\_] Yes, [\_\_] No

Bowel Movement: [\_\_] Yes, [\_\_] No

Urination: [\_\_] Yes, [\_\_] No

Sexual interest, desire, and drive: [\_\_] Yes, [\_\_] No

(For Females) Menstruation [\_\_] Yes [\_\_] No

**Functional Activities Status:**

Please ***check*** any of the following activities that **you *cannot* do:**

**i. Self-Care:**

[\_\_] Feeding

[\_\_] Picking and matching your clothes

[\_\_] Dressing and undressing

[\_\_] Toileting [\_\_] Grooming

**ii. Activities of daily living:**

[\_\_] Sitting up and down

[\_\_] Standing

[\_\_] Walking

[\_\_] Manual object transfer

[\_\_] Coordination

[\_\_] Balancing

[\_\_] Bending

[\_\_] Twisting

[\_\_] Turing

[\_\_] Movement and space negotiation

[\_\_] Transfer in and out of bed

[\_\_] Lying down

[\_\_] Rolling over

[\_\_] Lifting

[\_\_] Carrying

[\_\_] Pulling

[\_\_] Pushing

[\_\_] Stair ascending and descending

[\_\_] Child handling and care

[\_\_] Problems performing sexual activities

**iii. Household activities:**

[\_\_] Dish washing

[\_\_] Vacuuming

[\_\_] Doing the laundry

[\_\_] Gardening

[\_\_] Lawn mowing

[\_\_] Other necessary household activities

**iv. Transportation activities:**

[\_\_] Get in and out of vehicle

[\_\_] Climbing in and out

[\_\_] Sitting

[\_\_] Driving

[\_\_] Concentration and focus on driving

[\_\_] Maneuvering the vehicle

**v. Occupational Functional Activities:**

What is your occupational title? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you meet the physical demands of your job? [\_\_] Yes [\_\_] No

Can you meet the Mental Demands of your Job? [\_\_] Yes [\_\_] No

**vi. Do you have any physical limitations for intimate activities** *(kissing, caressing, hugging, intercourse)***?** [\_\_] Yes [\_\_] No

**Do you have limitations to manage Activity of Daily Living? [\_\_] Yes [\_\_] No**

Eating, Weight and Digestive Health

Do you think you are overweight: [\_\_] Yes, [\_\_] No?

Do you think you are under weight: [\_\_] Yes, [\_\_] No?

Do you refuse to eat to avoid gaining weight? [\_\_] Yes [\_\_] No

Are you scared of gaining weight? [\_\_] Yes [\_\_] No

Are you unhappy with your shape and looks? [\_\_] Yes [\_\_] No

Do you miss menstrual periods (if female)? [\_\_] Yes [\_\_] No

Do you eat substantially a lot in one seating? [\_\_] Yes [\_\_] No

Do you feel you have no control over your eating? [\_\_] Yes [\_\_] No

Do you make yourself throw-up or vomit (throw up)? [\_\_] Yes [\_\_] No

Do you use laxatives or enema to lose weight? [\_\_] Yes [\_\_] No

Do you fast often or exercise a lot to lose weight? [\_\_] Yes [\_\_] No

Do you have low self-esteem because of your weight? [\_\_] Yes [\_\_] No

Do you feel you lack confidence because of your weight? [\_\_] Yes [\_\_] No

Do you have urges to eat even when you are not hungry? [\_\_] Yes [\_\_] No

Do you feel guilty or ashamed after you eat? [\_\_] Yes [\_\_] No

Do you have exercise equipment that you do not use? [\_\_] Yes [\_\_] No

Do you consider yourself a diet failure? [\_\_] Yes [\_\_] No

Do you think your weight is affecting your health and or lifestyle, relations, employment?

[\_\_] Yes, [\_\_] No

Do you have regular bowl movements? [\_\_} Yes [\_\_] No

Are you constipated or have diarrhea nearly most days? [\_\_] Yes [\_\_] No

Are you anxious or preoccupied with your bowl habits? [\_\_] Yes [\_\_] No

**Physical Symptoms Check List:**

Please check any of the following symptoms that you might be ***currently*** experiencing:

[\_\_] Headaches [\_\_] Double vision [\_\_] Dizziness

[\_\_] Chills [\_\_] Fever [\_\_] Night sweat

[\_\_] Fainting spells [\_\_] Shortness of breath [\_\_] Cough

[\_\_] Sputum production [\_\_] Chest pain on breathing [\_\_] Bloody sputum

[\_\_] Palpitation [\_\_] Heart pain [\_\_] Difficulty swallowing

[\_\_] Vomiting [\_\_] Constipation [\_\_] Bowel incontinence

[\_\_] Blood in vomit [\_\_] Tarry stool [\_\_] Rectal bleeding

[\_\_] Diarrhea [ [\_\_] Blood in urine [\_\_] Frequent urination

[\_\_] Pain on urination [\_\_] Difficulty to urinate [\_\_] Incontinence

[\_\_] Genital discharge [\_\_] Pelvic pain [\_\_] Muscle pain

[\_\_] Joint pain [\_\_] Swelling of joints [\_\_] Anxiety

[\_\_] Bluish discoloration of hands/feet

Do you have any physical ***aches and pains*** now? [\_\_] Yes [\_\_] No

Does pain affect your family, work, or school? [\_\_] Yes [\_\_] No

Are you on any currently on any medication for pain? [\_\_] Yes \_\_] No

Have seen more than 3 doctors for pain? [\_\_] Yes [\_\_] No

Are you on any currently on any medication for pain? [\_\_] Yes [\_\_] No

*Neurological Disease History:*

Do you have any neurological problems you are aware of? [\_\_] Yes [\_\_] No

***Neurological disease history; Check any neurological diseases you have, had?***

[\_\_] [Amyotrophic lateral sclerosis (ALS)](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/als.aspx)

[\_\_] Alzheimer’s disease [\_\_] [Aneurysm](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/aneurysm/) [\_\_] Back pain

[\_\_] Bell’s palsy [\_\_] Brain injury [\_\_] Fibromyalgia

[\_\_] Birth defects of the brain and spinal cord [\_\_] [Brain tumor](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/brain-tumor-center/)

[\_\_] Cerebral palsy [\_\_] Chronic fatigue syndrome [\_\_] [Concussion](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/headache-and-concussion/default.aspx)

[\_\_] Dementia [\_\_] Disk disease of neck and or lower back

[\_\_] Dizziness [\_\_] [Epilepsy](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/epilepsy/default.aspx) [\_\_] Guillain-Barre syndrome

[\_\_] [Headaches and migraines](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/migraine-headache/) [\_\_] [Multiple sclerosis](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/multiple-sclerosis.aspx)

[\_\_] Muscular dystrophy [\_\_] Neuralgia [\_\_] Neuropathy

[\_\_] Neuromuscular and related diseases [\_\_] [Parkinson’s disease](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/parkinsons-disease.aspx)

[\_\_] Scoliosis [\_\_] [Seizures](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/epilepsy/?gclid=Cj0KCQiAmuHhBRD0ARIsAFWyPwisLUjbNV2yKSXIqzwVKXG9aIrfuRxb8n66cLP2ZZ_maKrrcWT9taUaAkz5EALw_wcB) [\_\_] [Spinal cord injury](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/spine-surgery.aspx)

[\_\_] Spinal deformity and disorders [\_\_] Chronic Fatigue Disorder

[\_\_] Spine tumor [\_\_] [Stroke](https://nortonhealthcare.com/services-and-conditions/neurosciences/services/stroke.aspx) [\_\_] Vertigo [\_\_] Dizziness

**Neurological Symptoms Check List:**

* Do you have a partial or complete paralysis? [\_\_] Yes [\_\_] No
* Do you have any Muscle **Weakness**? [\_\_] Yes [\_\_] No
* Do you have / had any partial or complete loss of sensation? [\_\_] Yes [\_\_] No
* Have you ever had any **Seizures**? [\_\_] Yes [\_\_] No
* Do you have any difficulty reading and writing? [\_\_] Yes [\_\_] No
* Do you have any difficulties with choosing your words, doing basic math, and planning? [\_\_] Yes [\_\_] No

Do you experience any unexplainable pain? [\_\_] Yes [\_\_] No

* Do you experience any reduction or loss of being Alert? [\_\_] Yes [\_\_] No
* Do feel restless you have any difficulty to stay still? [\_\_] Yes [\_\_] No
* Do you have any difficulty with your movements? [\_\_] Yes [\_\_] No
* Do you have any ticks or abnormal movements? [\_\_] Yes [\_\_] No

***Psychiatric Disorders History:***

***Check the proper box if you were diagnosed and or treated for any of the following Psychiatric Disorders:***

[\_\_] Schizophrenia [\_\_] Schizoaffective [\_\_] Bipolar

[\_\_] Anxiety [\_\_] Addiction [\_\_] Depression [\_\_] Personality Disorders

[\_\_] OCD [\_\_] PTSD [\_\_] Autism [\_\_] Asperger

[\_\_] Borderline Disorder

**Psychiatric and mental health treatment history:**

Have you ever used any psychiatric and mental health services?

[\_\_] Yes [\_\_] No

Are you currently taking any Mental Health Medications? [\_\_] Yes [\_\_] No

Have you ever had any ***voluntary*** psychiatric hospitalization? [\_\_] Yes [\_\_] No

Have you ever had any ***involuntary*** psychiatric hospitalization? [\_\_] Yes [\_\_] No

***Psychiatric Symptoms Check List:***

Check the proper boxes if you *CURRENTLY* experience any of the following symptoms:

[\_\_] Worthlessness [\_\_] Hopelessness [\_\_] Too much guilt [\_\_] Helplessness

[\_\_] Elated (high) [\_\_] Obsessed [\_\_] Annoyed [\_\_] Irritable

[\_\_] Unusual power

[\_\_] Depression [\_\_] Racing thought [\_\_] Paranoia [\_\_] Hallucination

How is your memory? [\_\_] Good [\_\_] Fair [\_\_] Poor

How is your attention span? [\_\_] Good [\_\_] Fair [\_\_] Poor

How is your concentration? [\_\_] Good [\_\_] Fair [\_\_] Poor

How is your mood and spirit? [\_\_] High [\_\_] Low [\_\_] Normal [\_\_] Sad [\_\_] Angry [\_\_] Irritable [\_\_] Nervous / anxious [\_\_] Calm

Do you have intense fears (phobias)? [\_\_] Yes [\_\_] No

Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever *heard Unreal Sounds or Voices* that others do not hear?

[\_\_] Yes [\_\_] No

Have you ever **seen** *Unreal visions* that others do not, see? [\_\_] Yes [\_\_] No

Do you have any thoughts or behaviors that you cannot seem to stop?

[\_\_] Yes [\_\_] No

Do you have beliefs that others find unusual and do not believe in?

[\_\_] Yes [\_\_] No

Have you ever tried to harm (cutting, injuring) yourself? [\_\_] Yes [\_\_] No

Have you ever tried suicide (trying to kill yourself): [\_\_] Yes [\_\_] No?

Do you currently or have you recently had **thoughts** of harming yourself?

[\_\_] Yes [\_\_] No

Do you currently have any **intentions** to harm yourself? [\_\_] Yes [\_\_] No

Have you ever tried to harm (cutting, injuring) others? [\_\_] Yes [\_\_] No

Did this require medical treatment? [\_\_] Yes [\_\_] No

Do you currently have, or have you recently had **thoughts** of harming others?

[\_\_] Yes [\_\_] No

Do you currently have any **intention**s to harm **others**? [\_\_] Yes [\_\_] No

**iii. Substance Abuse History**

**Current or past alcohol and substance use history**

Tobacco use:

Have you ever used tobacco? [\_\_] Yes [\_\_] No

Do you think Tobacco use is harmful to your health? [\_\_] Yes [\_\_] No

Has anyone ever complained about your tobacco use? [\_\_] Yes [\_\_] No

Has your use of tobacco ever caused you problems? [\_\_] Yes [\_\_] No

Has anyone ever complained about your tobacco use? [\_\_] Yes [\_\_] No

Cannabis (Marijuana)

Have you ever used **Cannabis (Marijuana)**? [\_\_] Yes [\_\_] No

Has anyone ever complained about your marijuana use? [\_\_] Yes [\_\_] No

Alcohol use

Have you ever used alcohol? [\_\_] Yes [\_\_] No

Have you ever felt you ought to cut down on your drinking? [\_\_] Yes [\_\_] No

Have people annoyed you by criticizing your drinking? [\_\_] Yes [\_\_] No

Have you ever felt bad or guilty about your drinking? [\_\_] Yes [\_\_] No

Have you ever had a drink the first thing in the morning to steady your nerves or get rid of a hangover? [\_\_] Yes [\_\_] No

Have you ever used mood altering drugs? [\_\_] Yes [\_\_] No

Prescription Drugs

Do you use more than 5 prescription drugs? [\_\_] Yes [\_\_] No

Do you take Xanax, Valium, Lortab, Percocet, Klonopin? [\_\_] Yes [\_\_] No

Nonprescription and illegal drug use:

**Name all drugs (street, illegal, recreational) that you have ever used:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Drug | Age first use | Age regular use | Amount currently used | How often use | Date of last use and amount |
|  |  |  |  |  |  |
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Have you used nonprescription drugs in the past ***30 days*?** [\_\_] Yes [\_\_] No

Have you used nonprescription drugs in the past ***48 hours****?* [\_\_] Yes [\_\_] No

Have you ever experienced memory loss when drinking or using drugs?

[\_\_] Yes [\_\_] No

Have you ever felt that you ought to cut down on your drug use?

[\_\_] Yes [\_\_] No

Have you ever felt you ought to increase or cut down drinking or using drugs to deal with any of the following feelings?

[\_\_] Depression [\_\_] Anxiety [\_\_] Anger [\_\_] Paranoia [\_\_] Hallucinations

[\_\_] Hyperactivity

**[\_\_] Yes [\_\_] No**

Have you ever used alcohol or drugs to bring about yourself any of the following feelings?

Cheer up, Calm down, steady your nerves, Reduce hallucinations,

Feel better, Help cope with emotional problems [\_\_] Yes [\_\_] Np

Have you ever used IV drugs? [\_\_] Yes [\_\_] No

Have you ever had any substance abuse counseling or rehab? [\_\_] Yes [\_\_] No

Has anyone in your family ever had a problem with alcohol or other drugs?

[\_\_] Yes [\_\_] No

Have you even been in trouble with the law or had run in with law enforcement because of prescription, or nonprescription drugs or alcohol? [\_\_] Yes [\_\_] No

**Conclusion**

If your answers to ***majority*** of these questions are [Yes], you must seriously consider seeing your doctor ASAP.

If your answers to ***most*** of the questions in this questioner is [Yes], you must consider seeing your doctor soon.

If your answers to these questions are completely [No], keep your regular preventive check up with your doctor.

***This service is the Courtesy of Sunshine Behavioral Medicine for public.***