Comprehensive Health Assessment

Before you start

This assessment helps your care team understand your overall health. Please answer every question honestly and fill the checkboxes completely using a blue or black pen. Write clearly inside the boxes. All answers are kept confidential in your health record.

Personal details

Full name

Date of birth

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Gender *(Please cross one)*

- ◯ Male
- ◯ Female
- ◯ Non-binary
- ◯ Prefer not to say

Phone number

Email address

To respond ⊗ *or* ●

Lifestyle

Do you currently smoke or use tobacco products? *(Please cross one)*

- ◯ Yes, daily
- ◯ Yes, occasionally
- ◯ No, I have quit
- ◯ No, I have never smoked

How often do you drink alcohol? *(Please cross one)*

- ◯ Never
- ◯ Monthly or less
- ◯ 2 to 4 times a month
- ◯ 2 to 3 times a week
- ◯ 4 or more times a week

How many days per week do you exercise for 30 minutes or more? *(Please cross one)*

- ◯ None
- ◯ 1 to 2 days
- ◯ 3 to 4 days
- ◯ 5 or more days

On average, how many hours do you sleep per night? *(Please cross one)*

- ◯ Fewer than 5 hours
- ◯ 5 to 6 hours
- ◯ 7 to 8 hours
- ◯ More than 8 hours

How often do the following apply to you?

Please cross one in each line	*Never*	*Rarely*	*Sometimes*	*Often*	*Daily*
I eat five or more servings of fruit and vegetables	◯	◯	◯	◯	◯
I eat fast food or takeout meals	◯	◯	◯	◯	◯
I drink sugary drinks such as soda or energy drinks	◯	◯	◯	◯	◯
I feel rested when I wake up in the morning	◯	◯	◯	◯	◯
I spend time outdoors or in nature	◯	◯	◯	◯	◯
I take time to relax and unwind	◯	◯	◯	◯	◯

Medical history

Have you ever been diagnosed with any of the following conditions?

	Please cross one in each line *Yes*	*No*
High blood pressure	◯	◯
High cholesterol	◯	◯
Heart disease	◯	◯
Stroke	◯	◯
Diabetes	◯	◯
Asthma or chronic lung disease	◯	◯
Cancer	◯	◯
Kidney disease	◯	◯
Liver disease	◯	◯
Thyroid disorder	◯	◯
Arthritis or joint problems	◯	◯
Depression or anxiety	◯	◯

Please list all medications and supplements you currently take, including doses if known

Please list any allergies to medications, foods, or other substances, and describe the reaction

To respond ⊗ or ●

Family history

Has a parent, sibling, or grandparent been diagnosed with any of the following?

Please cross one in each line	*Yes*	*No*
Heart disease	○	○
High blood pressure	○	○
Stroke	○	○
Diabetes	○	○
Cancer	○	○
Osteoporosis	○	○
Mental health conditions	○	○
Alzheimer's disease or dementia	○	○

If you answered yes above, please note which relative and their approximate age at diagnosis

To respond ⊗ or ●

Current symptoms

In the past month, how much have the following symptoms bothered you?

Please cross one in each line	*Not at all*	*Mild*	*Moderate*	*Severe*
Headaches	○	○	○	○
Chest pain or tightness	○	○	○	○
Shortness of breath	○	○	○	○
Persistent cough	○	○	○	○
Stomach pain or digestive problems	○	○	○	○
Joint or muscle pain	○	○	○	○
Back or neck pain	○	○	○	○
Dizziness or lightheadedness	○	○	○	○
Unusual fatigue or low energy	○	○	○	○
Changes in appetite or weight	○	○	○	○

Approximately when did your main symptom begin?

☐☐ / ☐☐
D D M M

To respond ⊗ *or* ●

Mental wellbeing

Over the past two weeks, how often have you experienced the following?

Please cross one in each line	*Never*	*Rarely*	*Sometimes*	*Often*	*Always*
Feeling nervous, anxious, or on edge	○	○	○	○	○
Feeling down or hopeless	○	○	○	○	○
Little interest or pleasure in daily activities	○	○	○	○	○
Trouble falling or staying asleep	○	○	○	○	○
Difficulty concentrating on everyday tasks	○	○	○	○	○
Feeling irritable or short-tempered	○	○	○	○	○
Feeling supported by family and friends	○	○	○	○	○

Overall, how would you rate your wellbeing today?

Very poor ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ Excellent

To respond ⊗ or ●

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Consent and signature

Declaration

I confirm that the information I have provided on this health assessment is accurate and complete to the best of my knowledge. I understand that it will be stored securely in my health record and used only by my care team to plan and provide my care.

Patient signature

Date signed

D D / M M / Y Y Y Y

Thank you for completing this health assessment. Please return the form to a member of staff at the front desk or hand it to your clinician at your appointment.

To respond ⊗ or ●