Best Life
Initial Assessment
Packet

Updated: May 19,2014

UFHealth PHYSICIANS **Department of Psychiatry**

PATIENT INFORMATION

NAME IN FULL	☐ F ☐ M	AGE	DATE OF BIRTH	TODAY'S DATE
ADDRESS				
CITY	COUNTY		STATE	ZIP CODE
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER		CELL NUMBER	MARITAL STATUS
OCCUPATION	EMPLOYER			
REASON FOR APPOINTMENT	REFERRED BY /HOW DID YOU HEAR ABOUT US			

COMPLETE IF PATIENT IS A MINOR

MOTHER'S NAME	FATHER'S NAME
CUSTODY ☐Both Parents ☐Mother ☐Father ☐Other _____	LIVES WITH ☐Both Parents ☐Mother ☐Father ☐Other_____
PARENT'S/CONTACT'STELEPHONE NUMBER	TELEPHONE NUMBER FOR

EMERGENCY CONTACT

NAME	RELATIONSHIP TO PATIENT	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER
ADDRESS	CITY	STATE	ZIP CODE

CONTACTS

PRIMARY CARE PHYSICIAN	SPECIALTY	LAST APPOINTMENT	HOW LONG HAVE THEY TREATED YOU?
CITY	STATE	PHONE NUMBER	

PSYCHIATRIST		LAST APPOINTMENT	HOW LONG HAVE THEY TREATED YOU?
CITY	STATE	PHONE NUMBER	

THERAPIST		LAST APPOINTMENT	HOW LONG HAVE THEY TREATED YOU?
CITY	STATE	PHONE NUMBER	
HOW OFTEN DO YOU MEET?	DO YOU FIND IT HELPFUL?		
IF NOT CURRENTLY IN THERAPY, HAVE YOU BEEN IN THE PAST?	IF SO, WAS IT HELPFUL?		

NUTRITION THERAPIST		LAST APPOINTMENT	HOW LONG HAVE THEY TREATED YOU?
CITY	STATE	PHONE NUMBER	
HOW OFTEN DO YOU MEET?	DO YOU FIND IT HELPFUL?		
IF NOT CURRENTLY IN THERAPY, HAVE YOU BEEN IN THE PAST?	IF SO, WAS IT HELPFUL?		

Medical/Psychology History

MEDICAL AND MENTAL HEALTH PROBLEMS for which you are being treated:		
PROBLEM	DOCTOR	HOW TREATED
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

SURGERIES you have had:	
SURGERY	WHEN
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

MEDICATIONS and over-the-counter pills you are taking:		
NAME OF MEDICATION	DOSAGE	HOW OFTEN TAKEN
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

ALLERGIES:	
Are you allergic to any medications? ☐ Yes ☐ No If so please list:	
DRUG	**PROBLEM**
1.	
2.	
3.	
4.	
5.	

Do you have any food allergies? ☐ **Yes** ☐ **No** **If so please list:**

Current Medical Concerns

Check all that apply

Cardiovascular

	Heart problems Requiring medication?
	Chest pains
	Racing heart/skipping
	High blood pressure Requiring medication?
	Chest tightness
	Shortness of breath
	High cholesterol Requiring medication?
	High triglycerides Requiring medication?
	Feel tired all the time

Diabetes

	Diabetes - Type I or II Requiring medication?
	Pre-diabetic Elevated blood sugar?
	Gestational diabetes Age of Diagnosis?
	Hypoglycemia (low blood sugar

Thyroid Problems

	Hypothyroidism
	Hyperthyroidism

Gastrointestinal

	Gallbladder problems Removed?
	Stomach ulcers Requiring medication?
	Heartburn Daily? Nocturnal?
	Regurgitation Requiring medication?
	Diarrhea Requiring medication?
	Constipation Requiring medication?

Respiratory

	Asthma Last attack?
	Bronchitis # of times in past 2 years Is it recurring?
	Pneumonia # of times in past 2 years
	Blood clots in lungs
	Smoker Starting age? When did you stop?
	Smokeless tobacco
	Snore
	Wake up gasping or with a smothered feeling

Musculoskeletal

Location	**Mild**	**Moderate**	**Severe**
Hip pain			
Knee pain			
Ankle pain			
Feet pain			
Back pain			
Neck pain			
Arthritis			

Females Only - Menstrual History

Are you currently menstruating? ☐ Yes ☐ No ☐ Have never menstruated

Date of last menstrual cycle _____

Are your periods regular?_____

Any difficulty conceiving?_____

Are you taking birth control pills/patches/injections or utilizing another form of birth control to prevent pregnancy?_____**If so, what?**_____

Are you currently breast feeding?_____

How many times have you been pregnant? _____ How did you deliver? _____

Family and Social History

Did you ever experience any of the following during your childhood or adolescence?

FAMILY:

- Death of a parent ☐
- Death of other loved one or close friend ☐
- Life threatening illness in immediate family ☐
- Separation from a parent for > a month ☐
- Parent's separation/divorce ☐
- Loss of home through natural disaster ☐
- Family financial problems ☐
- Parent with substance abuse problem ☐
- Significant conflict with parents ☐
- Foster care ☐

ABUSE/TRAUMA:

- Physical abuse ☐
- Sexual abuse ☐
- Verbal/Emotional abuse ☐
- Neglect ☐
- Rape ☐
- Other traumatic event
  If yes, please explain: _____

EDUCATION:

What's the farthest you've gone in school?

What grades did you make in school?

What is your occupation/career? How long have you worked in this capacity? _____

_____

What, if any, legal problems have you had? _____

What stresses are in your life now? _____

_____

What is your current living situation? _____

Describe your social support system: _____

Are you currently married? ☐ Yes ☐ No How many times have you been married? _____

How many children do you have? _____ Their ages: _____

Have you ever been hospitalized for mental illness or substance abuse: __yes __no
If yes, **please explain:**

Please check which substances you have used in your lifetime:

	Current	Past	Date of last use:		Current	Past	Date of last use:
Alcohol	☐	☐		Amphetamines/stimulants	☐	☐	
Tobacco	☐	☐		Tranquilizers/benzos (Ativan,Klonopin, Xanax)	☐	☐	
Marijuana/Spice/ K2	☐	☐		Opiates/pain pills	☐	☐	
Cocaine/ crack	☐	☐			☐	☐	
Heroin	☐	☐		Soma/muscle relaxants	☐	☐	
GHB	☐	☐		Ultram/tramadol	☐	☐	
Ecstasy	☐	☐		Inhalants	☐	☐	
LSD or Mushrooms	☐	☐		Nitrous oxide	☐	☐	
PCP	☐	☐		IV Drugs:	☐	☐	
Ketamine (special "K")	☐	☐		Other:	☐	☐	

Please answer the following:	Yes	No
How many drinks do you need to feel a buzz/"high"? _____		
Are you or others concerned with how much you drink?	☐	☐
Do you need a drink in the morning?	☐	☐
Do you have periods of time you don't remember associated with your drinking?	☐	☐
Have you ever blacked out from drinking?	☐	☐
Have you tried to cut down your drinking?	☐	☐

Weight & Diet History:

How do you feel about your body?:

_____

_____

Describe in your words how obesity is affecting your life:

_____

_____

What is your primary motivation for losing weight?

_____

_____

What do you think is the primary reason for your weight gain?

____injury	____ lack of exercise	____ pregnancy	____overeating
____poor eating habits	____ heredity	____ marriage	____stress
____smoking cessation	____ divorce	____ food addiction	

What is your **highest** weight? _____lbs when?_____
What is your **lowest** weight? _____lbs when?_____
What is your desired weight range? _____lbs to _____lbs

Activity/Exercise History:

What is your regular activity level:

Minimally active: (very sedentary, rarely leave the house)	☐
Somewhat active: (light housework, gardening, walking on errands or while working)	☐
Moderately active: (exercise 1-3 times a week, walking for exercise)	☐
Very active: (exercise 3 or more times a week, e.g. aerobics, running, swimming, weight training, cycling)	☐
Extremely active: (daily vigorous exercise)	☐

What are your favorite activities or exercises?

_____

_____

What physical activities are you currently engaged in? _____

Meals:

How many meals per day do you eat?
___1 meal ___1-2 meals ___2 meals ___2-3 meals ___3 meals ___3 or more meals

Do you skip meals? ___yes ___no
If yes, what meal(s) do you usually skip? _____
How many days a week do you skip this meal? _____
Do you skip meals to control your weight? _____

Are your meals:
___large portions ___extra large portions ___high fat ___high in carbs ___high in sugar

How often do you snack:
___a.m. snack ___p.m. snack ___evening snack ___snack between all meals

What are your favorite snacks? _____

What beverages do you drink?

___water	___whole milk	___2% milk	___1%milk
___skim milk	___regular soda	___diet soda	___regular coffee
___decaf coffee	___regular tea	___decaf tea	___juice
___sweet tea	___unsweetened tea		

How often do you eat out? _____

Do you eat rapidly? ___yes ___no

Do you eat in secret or hide food? ___yes ___no
If yes, why? _____

Do you consider yourself a binge eater? ___yes ___no
If yes, what do your consume during a binge?
_____
_____

If yes, how often do you binge? _____
If yes, do you feel out of control when you binge? ___yes ___no

Do you eat large amounts of food when you're not hungry? ___yes ___no

Do you eat more than you intended to at one sitting? ___yes ___no

Do you feel guilty after you have eaten? ___yes ___no
If yes, why? _____

Do you feel like you're an emotional eater? ___yes ___no
If so, please describe:_____

Have you ever used laxatives to assist with weight loss? ___yes ___no

Have you ever used diuretics for weight loss? ___yes ___no
Do you induce vomiting? ___yes ___no If yes, how many times a day? _____

Do you exercise excessively to compensate for food you have eaten? ___yes ___no

About how many calories do you think you eat a day? _____

How hungry do you let yourself get:
(not hungry at all) 0---1---2---3---4---5---6---7---8---9---10 (so hungry you get cramps)

Dieting History

When did your weight problem begin? _____
Have you ever tried to control your weight? ☐ Yes ☐ No

If yes, age at first attempt: ____ years
Your height at that time: _____ **Your weight at that time**: _____
Why did you go on the diet?

_____
_____

Which diets have you tried:					
Weight Watchers	☐	Food Pyramid	☐	Beverly Hills diet	☐
Nutri/System	☐	Diabetic diet	☐	Scarsdale Diet	☐
Jenny Craig	☐	Liquid Diet	☐	Hollywood 48 hour diet	☐
LA Weight Loss	☐	Optifast	☐	Celebrity diet	☐
Richard Simmons	☐	Body For Life	☐	The Grapefruit diet	☐
Slimfast	☐	Fit For Life	☐	Cabbage soup diet	☐
Metabolife	☐	Medifast	☐	Mediterranean diet	☐
Atkins	☐	Mayo Clinic diet	☐	Subway diet	☐
HCG Diet	☐	Pritkin diet	☐	Fasting	☐
The Zone	☐	Raw diet	☐	Caveman diet	☐
South Beach	☐	Blood Test diet	☐	Low Calorie	☐
Low Carb diet	☐	Negative Calorie diet	☐	how many calories a day _____	
Sugar Busters diet	☐	Cider Vinegar diet	☐	Other diets:	

What has been your most successful diet?

_____

Why do you suppose this was the case?

_____

Have you ever seen a nutritionist? ___yes ___no
What were their recommendations?

_____
Were their recommendations helpful? _____

Have you ever taken medications for weight loss (either over the counter or prescription)?____
If so, what have you taken?