LM Services

Laura Dwelley, RN
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Name: _____ Age: _____

Occupation: (current/former) _____ (desired occupation) _____

Height: _____ Weight: _____ Recent weight gain/loss in last 6 months? + _____ - _____

Do you smoke/use tobacco or nicotine? Yes No

Do you consider yourself physically healthy? Yes No

Rate physical health, on a scale of 1-10, (10 being the best health of your life) _____

Do you consider yourself emotionally healthy? Yes No

Rate emotional health, on a scale of 1-10, (10 being the best health of your life) _____

Describing your current health - Check any of the following that apply:

- Pain that disrupts activities of daily living or your quality of life Yes No
- The ability to exercise for as long and as often as you would like Yes No

  If not, please describe: _____
- Deep, restful sleep which refreshes you every day Yes No
- Stress, anxiety or fear which is sometimes overwhelming Yes No

Are you a caregiver for anyone? (how many) Child ____ Spouse ____ Parent ____

Diagnosed Medical conditions:

_____

_____

Medications: _____

_____

What else would you like us to know about you:

_____

_____

_____