Consumer ID: _____

General Health Information

THE right DOOR for hope, recovery and wellness

Name: _____

Today's Date: _____

Primary Care Doctor:_____ **Date Last Seen:**_____

1) On average, how many hours do you sleep each day: _____

Generally, do you feel rested when you awaken: Yes No

2) What types of physical activities do you participate in:

_____

_____

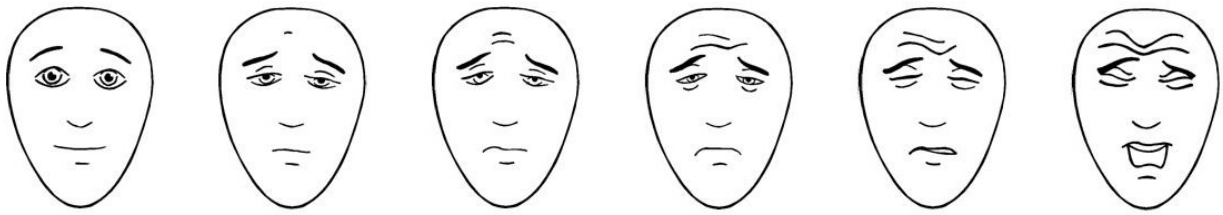
3) How many hours of physical activity do you get each week: _____

4) Do you experience any pain? Yes No

If yes, please rate your pain on a scale of 1 - 10 with 10 being unbearable pain or use the faces to describe your pain (Circle one).

1 2 3 4 5 6 7 8 9 10

BELOW: Score the chosen face 0, 2, 4, 6, 8, or 10, counting left to right, so "0" = "no pain" and "10" = "very much pain".



0 2 4 6 8 10

If yes, what is the cause of your pain? _____

_____

5) Do you have allergies (hay fever, food allergies, medications, etc.)? Yes No

- If yes, list allergies: _____

6) How many cups of caffeinated beverages (pop, coffee) do you drink per day? _____

7) Do you have difficulty with your teeth or have dental/mouth concerns? Yes No

- If Yes, explain: _____

Consumer ID: _____

SAFETY REVIEW

Do you wear a seatbelt in a moving vehicle?	Yes	No	
Do you use a car seat for any child under age 8 or under 4'9"?	Yes	No	
Do you know where to locate the number for Poison Control?.....	Yes	No	
Do you have any guns in the home?	Yes	No	
If yes, are they kept in a locked place?.....	Yes	No	
Do you keep knives and other harmful objects out of reach of children?..	Yes	No	
Do you have a plan in case of a fire?.....	Yes	No	
Do you have a fire extinguisher in your home?.....	Yes	No	
Do you have a smoke detector in your home?.....	Yes	No	
Do you have a carbon monoxide detector in your home?.....	Yes	No	
Do you have a plan in case of a tornado?.....	Yes	No	
Do you feel safe at home?.....	Yes	No	N/A
Do you feel safe at school?.....	Yes	No	N/A
Do you feel safe at work?.....	Yes	No	N/A

Additional comments on safety concerns you may have:

Would you like help connecting with a health care provider?	Yes	No
Would you like to meet with a nurse for help in creating a Wellness Plan for yourself?	Yes	No

Clinician Recommendations & Comments:

Consumer Signature:_____ **Date:** _____

Primary Clinician Signature:_____**Date:** _____