



Empowering Whole Health Initial Health Evaluation Form

Adapted from the Sample Chronic Disease Questionnaire, Aug 2007, by Stanford Patient Education Research Center, Stanford University School of Medicine, on 11.27.14 <http://patienteducation.stanford.edu/research/download/html>

Name: _____ Today's date: _____

General Health

1. In general, would you say your health is:
(Circle One)

Excellent
1

Very Good
2

Good
3

Fair
4

Poor
5

Symptoms

How much time during the **past 2 weeks...**

	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
1. Were you discouraged by your health problems?	0	1	2	3	4	5
2. Were you fearful about your future health?	0	1	2	3	4	5
3. Was your health a worry in your life?	0	1	2	3	4	5
4. Were you frustrated by your health problems?	0	1	2	3	4	5

Confidence About Doing Things

For each of the following questions, please **circle** the number that corresponds with your **confidence** that you can do the tasks regularly at the present time.

Circle the n/a box if the symptom does not apply to you.

How confident are you that you can.....

1. Keep the fatigue caused by your health problems from interfering with the things you want to do?	Not at all _____ Totally Confident Confident 1 2 3 4 5 6 7 8 9 10	n/a
2. Keep the physical discomfort or pain of your health problem from interfering with the things you want to do?	Not at all _____ Totally Confident Confident 1 2 3 4 5 6 7 8 9 10	n/a
3. Keep the emotional distress caused by your health problem from interfering with the things you want to do?	Not at all _____ Totally Confident Confident 1 2 3 4 5 6 7 8 9 10	n/a
4. Keep any other symptoms or health problems you have from interfering with the things you want to do?	Not at all _____ Totally Confident Confident 1 2 3 4 5 6 7 8 9 10	n/a
5. Do the different tasks and activities needed to manage your health problem so as to reduce your need to see a doctor?	Not at all _____ Totally Confident Confident 1 2 3 4 5 6 7 8 9 10	n/a
6. Do things other than just taking medication to reduce how much your health problem affects your everyday life?	Not at all _____ Totally Confident Confident 1 2 3 4 5 6 7 8 9 10	n/a

Daily Activities

During the **past 2 weeks**, how much...

(Circle ***one***)

	Not at all	Slightly	Moderately	Quite a bit	Almost Totally
1. Has your health interfered with your normal activities with family, neighbors or groups?	0	1	2	3	4
2. Has your health interfered with your hobbies or recreational activities?	0	1	2	3	4
3. Has your health interfered with your household chores?	0	1	2	3	4
4. Has your health interfered with your errands and shopping?	0	1	2	3	4

Medical Care

1. When you **visit your doctor**, how often do you do the following (please circle one number for each question):

	Never	Almost never	Some times	Fairly Often	Very often	Always
Prepare a list of questions for your doctor?	1	2	3	4	5	6
Ask questions about the things you want to know and things you don't understand about your treatment?	1	2	3	4	5	6
Discuss any personal problems that may be related to your illness?	1	2	3	4	5	6

2. **In the past 3 months**, how many times did you visit a physician? ____visits
Do not include visits while in the hospital or the hospital emergency department.
3. **In the past 3 months**, how many times did you go to a hospital emergency department? ____times
4. **In the past 3 months**, how many times were you hospitalized for one night or longer? ____times
- a. **How many total NIGHTS** did you spend in the hospital **in the past 3 months**? ____nights
- b. **Were any** of these hospitalizations at a skilled nursing facility, convalescent hospital, or other minimum care facility? (circle) Yes No

Thank you for your help!