Health Assessment

Yes	No	Have you had an eye exam in the last year?	Name:
Yes	**No**	Do you, or a family member, have glaucoma?	Date of birth:
Yes	**No**	Do you feel like you may need a hearing aid?	Today's date:
Yes	No	Do you have an Advance Directive document?	
Yes	**No**	Do you use a cane, walker, or wheelchair?	
Yes	**No**	Have you fallen in the last year?	
Yes	**No**	Do you feel sad?	
Yes	No	Do you feel safe?	
Yes	**No**	Are there any things in your home that could cause you to slip or trip?	
Yes	**No**	Is anyone hurting you, yelling at you, putting you down, stealing from you?	
Yes	No	Do you have enough food?	
Yes	No	Is your weight staying the same?	
Yes	**No**	Do you think you may have problems with your memory?	
Yes	**No**	Do you drink excess alcohol?	
Yes	**No**	Do you use marijuana, or other drugs?	
Yes	**No**	Do you smoke?	
Yes	**No**	Have you ever smoked?	
Yes	No	Do you exercise regularly?	
Yes	No	Have you had a dental exam in the last year?	
Yes	No	Do you brush your teeth at least once daily?	
Yes	No	Do you use sunscreen when you go outside?	
Yes	**No**	Do you have any skin spots you are worried about?	
Yes	No	Do you wear a seatbelt in the car?	
Yes	**No**	Do you ever get lost driving?	
Yes	**No**	Do you ever drive after you have had alcohol to drink?	
Yes	**No**	Do you have any pain?	
Yes	No	Does your digestive system work well?	
Yes	**No**	Do you need help with bathing, dressing, shopping, cooking, laundry, driving, money?	

AMERICAN COLLEGE OF Lifestyle Medicine

LOMA LINDA UNIVERSITY HEALTH

Produced in collaboration with Loma Linda University

Lifestyle Assessment Short Form

OVERALL HEALTH

1. Please circle your current overall LEVEL of HEALTH.

0 Very poor health 1 2 3 4 5 6 7 8 9 10 Excellent health

SLEEP

2. OVER THE LAST TWO WEEKS, how many hours of sleep did you average in a 24-hour period?

a. Less than 4 hours
b. 4-5 hours
c. 6 hours
d. 7-8 hours
e. 9 or more hours

3. OVER THE LAST TWO WEEKS, how often did you feel tired or have difficulty staying awake during routine tasks in the day?

a. Not at all
b. Several days
c. More than half the days
d. Nearly every day

WEIGHT MANAGEMENT

4. What do you think about your current weight?

a. I want to gain a lot of weight
b. I want to gain a little weight
c. I am happy with my weight
d. I want to lose a little weight
e. I want to lose a lot weight

NUTRITION

5. OVER THE LAST TWO WEEKS, how often have you eaten fast food, sugary drinks (e.g., soda, sports drinks, juice) or packaged foods (e.g., chips, candy, crackers, cookies)?

a. Not at all
b. Several days
c. More than half the days
d. Nearly every day

6. ON AN AVERAGE DAY, how many servings of whole fruits and vegetables do you eat (1 serving is about a handful and does not include fruit juice)?

a. Less than 2 servings
b. 2-3 servings
c. 4-5 servings
d. More than 5 servings

EXERCISE

7. OVER THE LAST TWO WEEKS, how many days did you exercise at a moderate to strenuous intensity (e.g., brisk walking or enough movement to break a light sweat)?

a. Less than 1 time per week
b. 1-2 times per week
c. 3-4 times per week
d. 5 or more times per week

8. DURING AN AVERAGE SESSION, how many minutes do you exercise at a moderate to strenuous intensity (e.g., brisk walking or enough movement to break a light sweat)?

a. Less than 10 minutes
b. 10-29 minutes
c. 30-49 minutes
d. 50 minutes or more

Patient Name:_____ DOB: _____

PURPOSE & CONNECTION / MENTAL HEALTH

9. Over the past 2 weeks, how often have you…	Not at all	Several days	More than half the days	Nearly every day
a. Felt like your life had purpose or meaning?	3	2	1	0
b. Connected with any support network (e.g. community, spiritual, friends/family, nature, yoga, or meditation)?	3	2	1	0
c. Been bothered by little interest or pleasure in doing things?	0	1	2	3
d. Been bothered by feeling down, depressed or hopeless?	0	1	2	3
e. Been bothered by feeling nervous, anxious or on edge?	0	1	2	3
f. Been bothered by worrying too much about different things?	0	1	2	3

SMOKING/SUBSTANCE USE

Have you used any of the following substances in the past year?

10. NICOTINE (cigarettes, e-cigarettes/vaping, cigars) Yes No

If you marked "YES", how many cigarettes do you usually use? _____ a day

If you marked "YES", circle what level of concern you have regarding nicotine? 0 (No Concern) 1 2 3 4 5 (High Concern)

11. ALCOHOL (beer, wine, liquor) Yes No

If you marked "YES", how much alcohol do you usually use? _____ a day

If you marked "YES", circle what level of concern you have regarding your alcohol use? 0 (No Concern) 1 2 3 4 5 (High Concern)

12. RECREATIONAL DRUGS (cocaine, heroin, meth, etc.) Yes No

If you marked "YES", how much do you usually use? _____ a day

If you marked "YES", circle what level of concern you have regarding your recreational drug use? 0 (No Concern) 1 2 3 4 5 (High Concern)

13. MARIJUANA Yes No

If you marked "YES", how much marijuana do you usually use? _____ a day

If you marked "YES", circle what level of concern you have regarding your marijuana use? 0 (No Concern) 1 2 3 4 5 (High Concern)

MOTIVATION

14. Please rank the top THREE areas you are most motivated to change in order to improve your current overall LEVEL OF HEALTH (1 being most motivated).

Sleep _____ Weight Management _____ Nutrition _____

Exercise _____ Purpose & Connection _____ Mental Health _____

Substance Use _____

What motivates you to be healthier? _____

_____

_____

Patient Name:_____ DOB: _____

Patient Health Questionnaire-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Generalized Anxiety Disorder 7-item (GAD-7) scale

Date: _____ Name: _____ DOB: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____