Health Assessment

Patient information	
Name:	**Date of birth:**
Gender:	**Date of assessment:**
Mobile contact:	**Email contact:**
Address:	
Occupation:	
Current health recordings	
Weight:	**Height:**
Blood pressure:	**Temperature:**
How does the client rate their current health?	
◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10	
Chief complaint:	
Medical history	
Are there any medical concerns that you or your family members have had in the past? *E.g., stroke, cancer, cardiac issues, or skin issues.*	
Current medication(s)	

Allergies	
Medication:	
Food(s):	
Environmental factors (e.g., pollen, dust):	
Other (please specify):	
Lifestyle factors	
Do you smoke tobacco? ◯ Yes ◯ No	**If yes, please specify how often and the quantity:**
Do you drink alcohol? ◯ Yes ◯ No	**If yes, please specify how often and the quantity:**
Do you exercise often? ◯ Yes ◯ No	**If yes, please specify how often and what you typically do for exercise:**

Psychological health

How often do you experience stress?

How often do you experience sadness or low mood?

How often do you experience worry or fear?

What does your support system look like?

Additional notes