Biopsychosocial

Name: _____ Date: _____

Social:

1. What is your occupation?
2. Have you lost work because of this condition? ____ If yes, how many days? _____
3. Is this condition due to injury or sickness arising out of employment? ____ Auto Accident? _____ Other? ____
4. Do you exercise? If so, where and what type: _____
5. Do you smoke? No / Yes Packs / day? ____ No. of years? ____
6. Do you drink alcohol? Heavy / Moderate / Light Times per Week ____
7. Do you have small children? No / Yes How many? ____
8. Have you ever been in an auto accident? No / Yes When? ____
9. Have you ever seriously injured yourself from a fall or other trauma? _____
10. What operations have you had and when? _____
11. Serious illness and when? _____

REVIEW OF SYSTEMS: *Please explain any "YES" answers*

1. Eyes, ears, nose or mouth? No / Yes _____
2. Heart or lungs? No / Yes _____
3. Stomach, digestion (heart burn, indigestion), bowels, bowel movement or gastrointestinal track? No / Yes _____
4. Genitourinary system:
   female = fibroids, breast pain, cancer, PMS, pain associated with period, frequent yeast infections? No / Yes _____
   male = urinary difficulties, can you start and stop urination at will, prostate enlargement, cancer etc? No / Yes _____
5. Muscles, ligaments, bones, arthritis, … ? No / Yes _____
6. Nerves, MS, pinched nerve, shaking, tripping, unsteady walk, … ? No / Yes _____
7. Skin, sores, wound care, ... ? No / Yes _____
8. Psychiatric, bipolar, frequent depression, ... ? No / Yes _____
9. Do you seek professional counseling? No / Yes _____
10. Is stress a factor in your life? _____
11. Hormone issues / imbalance, hot flashes, autoimmune conditions, diabetes? _____
12. Blood or lymphatic problems? No / Yes _____
13. Are you currently loosing weight for unknown reasons? No / Yes _____
14. Do you have allergies or sensitivities? No / Yes _____
15. Other? _____

Family History:

1. Are there health related conditions that run or may run in your family, i.e., back problems, heart disease, cancer, diabetes, alcohol, etc.? No / Yes _____
2. Does or did your mother, father or siblings have allergies or sensitivities? _____

Activities of Daily Living:

1. How do you sleep, on your stomach, half stomach half side with one knee up, back , side or 'all over'?
2. Do you sit at a desk frequently? Yes / No
3. Does your back hurt when you vacuum? Yes / No
4. Do you drive more then 20 minutes per day on the highway? Yes / No
5. Do you have to lift or reach for items (any items) on a daily basis? Yes / No