Healthsprings 360 Wellness Form

Name: ______________________________________ **DOB**: ____________________

Marital Status: Single Married Domestic Partner Divorced Widow

Lives: Alone Spouse Institutional Family Other: ________________

What is your pain level today on a scale from 1-10?

0 1 2 3 4 5 6 7 8 9 10

Is bladder control a problem? **YES** **NO**

How many days a week are you physically active?

0-1 days **2-3 days** **4 or more days**

Family History:

	Father	Mother	Children	Siblings	Grandparents
Hypertension					
Heart Disease					
Stroke					
Diabetes					
High Lipids					
Dementia					
Depression					
Cancer					
Other					

Other (List history here):

____

Tobacco Use: YES NO

If YES, circle all that apply.

E-Cigarettes Current Smoker/Packer per Day _________

Current Chew/Dip Use Previous Smoker/Year Quit _________

Alcohol Use: YES NO

If YES, how many drinks per day? __________

Is alcohol usage a concern for you or others? YES NO

Questionnaire:

Have you felt depressed or down-and-out over the past 2 months? YES NO

Have you had a loss of interest in things that normally bring you pleasure? YES NO

Have you felt fatigued or had a loss of energy recently? YES NO

Preventive Screenings (If yes, please provide date & location):

Osteoporosis Screening: YES NO

Date: _______________ Location: ____

Mammogram: YES NO

Date: _______________ Location: ____

Colorectal Cancer Screening: YES NO

Date: _______________ Location: ____

Advanced Care Plan: YES NO

(If yes, please provide date):

Date:_______________ Did you provide a copy? YES NO

Vaccination History:

	YES	NO	DATE
Influenza Vaccine			
Pneumococcal Vaccine			
Shingles Vaccine			
Prevnar			
Covid			