Social
Action
Loma Linda

SAC NORTON FAMILY HEALTH SURVEY

We understand that there are many factors that have a great impact on your health such as finances, stress, feelings, family and friends. We at SAC Norton clinic believe it is important to pay attention to each of these areas. To help us provide our highest standard of care, please provide the following information.

Name:______________________________ Date:______________

Home Address:______________________________________

Phone Number: ( )__________________ Date of Birth:______________

Are you currently:
☐ Employed ☐ Unemployed ☐ Looking for work ☐ In school

Are you currently:
☐ Single ☐ Married ☐ Living with a partner ☐ Separated ☐ Divorced

In general, how would you rate your relationship with your partner?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ No Partner

In general, how would you rate your relationships with peers and/or family members?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Do not know

How many children do you have? __________ Ages______________

In general, how would you rate your child's or children's behavior?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ No Children

Are there any behaviors that you are particularly concerned about with your child(ren)?
☐ Yes, Which child?__________________ ☐ No ☐ No children in the home
What behaviors?__________________

Who do you go to when you feel hurt or sad?
☐ Family member(s) ☐ Friend(s) ☐ Professional ☐ Other__________

Have you experienced physical violence or trauma in the past 6 months?
☐ Yes, What?______________________________ ☐ No

Rate your level of stress:
☐ Not stressed ☐ Low stress ☐ Moderate stress ☐ High Stress

Have you had any physical symptoms for which the doctor has not found the cause?
☐ Yes, What?______________________________ ☐ No

Are there any other issues in which you may need assistance?
☐ Yes, What?______________________________ ☐ Not at this time

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Please make sure to check a box for every item

During the PAST MONTH, have you often been bothered by…

	YES	NO
1. Stomach pain	☐	☐
2. Back pain	☐	☐
3. Pain in your arms, legs, joints (knees, hips, etc)	☐	☐
4. Menstrual pain	☐	☐
5. Pain or problems during sexual intercourse	☐	☐
6. Headaches	☐	☐
7. Chest pain	☐	☐
8. Dizziness	☐	☐
9. Fainting spells	☐	☐
10. Felling your heart pound or race	☐	☐
11. Shortness of breath	☐	☐
12. Constipation, loose bowels, or diarrhea	☐	☐
13. Nausea, gas, or indigestion	☐	☐
14. Feeling tired or having low energy	☐	☐
15. Trouble sleeping	☐	☐
16. The thought that you have a serious undiagnosed disease.	☐	☐
17. Your eating being out of control	☐	☐
18. Little interest or pleasure in doing things	☐	☐
19. Feeling down, depressed, or hopeless	☐	☐
20. 'Nerves' or feeling anxious or on edge	☐	☐
21. Worrying about a lot of different things	☐	☐

During the PAST MONTH…

	YES	NO
22. Have you had an anxiety attack (suddenly feeling fear or panic)	☐	☐
23. Have you thought you should cut down on your drinking of alcohol	☐	☐
24. Has anyone complained about your drinking	☐	☐
25. Have you felt guilty or upset about your drinking	☐	☐
26. Was there ever a single day in which you had five or more drinks of beer, wine, or liquor	☐	☐

Overall, would you say your health is:

- Excellent ☐
- Very good ☐
- Good ☐
- Fair ☐
- Poor ☐

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Comments:

Name: ____________________
D.O.B: ____________________