Habits and Safety

- Do you have any problems with activities of daily living such as bathing, toileting or fixing meals? ☐ Yes ☐ No

  If yes, please explain: ____

- Do you currently smoke? ☐ Yes ☐ No   If no, were you a former smoker? ☐ Yes ☐ No

  If so, how many packs a day? ______ For how many years? _____

- Do you drink alcoholic beverages? ☐ Yes ☐ No   Amount per week? __________

  If you drink, have people ever criticized your drinking? ☐ Yes ☐ No

  If you drink, have you ever felt bad or guilty about your drinking? ☐ Yes ☐ No

- Have you ever used any recreational drugs like marijuana, cocaine, heroin or intravenous drugs? ☐ Yes ☐ No

- Do you have any guns or weapons in the home? ☐ Yes ☐ No   If yes, can your children get to them? ☐ Yes ☐ No

- Do you have a religious affiliation? ☐ Yes ☐ No (optional) If yes, what is your affiliation? _______________

- Are you very active or getting regular exercise? ☐ Yes ☐ No

Check any of the following that you would like to discuss:

☐ Alcohol/Drug use in home   ☐ Recent Death   ☐ Sexual Orientation

☐ Care of Aged/Ill Spouse/Parent   ☐ Care of Dependent/Grandchild

☐ Other Stress ____

____   _______________

Signature of Patient/Person Filling Out Form   Date

____   _______________

Provider Signature   Date