ACT/SJLIFE Questionnaire

The questions in this booklet relate to:

Person completing this questionnaire is:

Your relationship:

☐ Self ☐ Parent ☐ Other: _____

Today's date: ☐☐ / ☐☐ / ☐☐☐☐
m m d d y y y y

MRN: ☐☐☐☐☐

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1-800-775-2167

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Please! Do not mark below this line

Survey #241

8334063782

12/09/2016 10:59:40 AM

Current Health Problems (Review of Systems)

Are you/is your child **currently having problems** with any of the conditions below:

	No	Yes
Frequent headaches	☐	☐
Problems seeing	☐	☐
Problems hearing	☐	☐
Dizziness or unsteadiness	☐	☐
Problems walking	☐	☐
Frequently tired	☐	☐
Changes in appetite or eating habits	☐	☐
Sensitivity to heat or cold	☐	☐
Chest pain	☐	☐
Rapid or irregular heartbeat	☐	☐
Frequent or severe belly pain	☐	☐
Frequent constipation	☐	☐
Frequent diarrhea	☐	☐
Frequent need to urinate	☐	☐
Burning or pain with urination	☐	☐
Back pain	☐	☐
Any other chronic pain	☐	☐
Problems with menstrual periods	☐	☐
Heavy periods with excessive bleeding	☐	☐
Irregular or frequently missed periods	☐	☐
Severe cramping	☐	☐
Problems with sexual functioning	☐	☐
Problems with memory, thinking, forgetting which affect school or work performance	☐	☐
Problems controlling temper or anger	☐	☐
Difficulty getting along with others	☐	☐
Increased worries or upsetting thoughts	☐	☐
Problems with anxiety/panic attacks	☐	☐
Frequently feeling sad, blue or depressed	☐	☐
Problems sleeping or frequent use of sleep medicines	☐	☐
Increased use of tobacco, alcohol or other drugs	☐	☐
Use of over the counter weight loss medicine	☐	☐

→ *Please continue on next page.*

Please! Do not mark below this line

Medical Information

Please provide the name, address, and telephone number of the patient's physician and specialty physician.

Primary Care Physician:

Doctor's name
Street
City, State, Zip
Phone

Specialty Physician (Example: Endocrinologist):

Doctor's name
Street
City, State, Zip
Phone
Specialty

Specialty Physician (Example: Endocrinologist):

Doctor's name
Street
City, State, Zip
Phone
Specialty

Specialty Physician (Example: Endocrinologist):

Doctor's name
Street
City, State, Zip
Phone
Specialty

Interval History

Medical Check-Ups:

A1. Have you/your child seen a doctor since the last St. Jude visit?

☐ No → *Go to Question A3.*

☐ Yes

A2. Reason for doctor visit:

☐ Routine check-up; sports or school physical

☐ Illness; indicate approximate date and condition treated

Date
Doctor's name
Medical problem

Date
Doctor's name
Medical problem

A3. Have you/your child seen a dentist since the last St. Jude visit?

☐ No → *Go to Question A5, next page.*

☐ Yes

A4. Reason for dental visit:

☐ Routine check-up

☐ Dental Problem

If dental problem, please specify:

Please! Do not mark below this line

Hospitalizations

A5. Have you/your child been hospitalized since the last St. Jude visit?

☐ No

☐ Yes

Date	Hospital
Medical problem	

Date	Hospital
Medical problem	

Medications and Health Supplements

Medications: List the medicines you/your child take(s) regularly. Remember to include hormones, birth control pills and over the counter medicines.

Name of medicine	Dose of medicine	Reason taken	Prescribing MD

Health Supplements: List herbs, supplements and other natural products you/your child take(s) regularly.

Name of product	Reason taken

Please! Do not mark below this line