

Epworth Sleepiness Scale

Patient's Name _____ Today's Date _____

Age _____ Gender _____ Physician's Name _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you. Place an X in the corresponding space for each situation.

	- 0 - WOULD NEVER DOZE	- 1 - SLIGHT CHANCE OF DOZING	- 2 - MODERATE CHANCE OF DOZING	- 3 - HIGH CHANCE OF DOZING
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (e.g. a theatre or a meeting)				
A passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in the traffic				
TOTAL				

SCORING: 0-12 = Normal | 10-12 = Borderline | 12-24 = Abnormal

TOTAL SCORE

Beck Anxiety Inventory & Scoring



Patient's Name _____ Today's Date _____

Age _____ Gender _____ Physician's Name _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TODAY, by placing an X in the corresponding space in the column next to each symptom.

	- 0 - NOT AT ALL	- 1 - MILDLY It did not bother me much.	- 2 - MODERATELY It was very unpleasant, but I could stand it.	- 3 - SEVERELY I could barely stand it.
Numbness or tingling				
Feeling hot				
Wobbliness in legs				
Unable to relax				
Fear of the worst happening				
Dizzy or lightheaded				
Heart pounding or racing				
Unsteady				
Terrified				
Nervous				
Feelings of choking				
Hands trembling				
Shaky				
Fear of losing control				
Difficulty breathing				
Fear of dying				
Scared				
Indigestion or discomfort in abdomen				
Faint				
Face flushed				
Sweating (not due to heat)				
TOTAL				

MAXIMUM SCORE = 63 POINTS

0-7 = Minimal Anxiety | 8-15 = Mild Anxiety | 16-25 = Moderate Anxiety | 26-63 = Severe Anxiety

TOTAL SCORE

Female Sexual Function Screener

Support services provided by



Patient's Name _____ Today's Date _____

Age _____ Gender _____ Physician's Name _____

These questions ask about your present experience. Circle the response that best describes your own situation. Please be sure that you select only one response for each question.

A. Are you satisfied with your level of sexual desire or interest?

- 0. Always
- 1. Most Times
- 2. Sometimes
- 3. Never

B. Are you satisfied with your level of lubrication during sexual activity or intercourse?

- 0. Always
- 1. Most Times
- 2. Sometimes
- 3. Never

C. Are you satisfied with your overall sexual life?

- 0. Satisfied
- 1. Neutral
- 2. Dissatisfied

D. Do you experience discomfort or pain during sexual activity or intercourse?

- 0. Yes
- 1. No

SCORING: 0-3 = No action | 4-10 = Assess further

TOTAL SCORE

Name: _____ DOB: _____

Nutrition Assessment Form

Please check if you are currently taking any of the following:

- Multi-vitamins: brand: _____
- Single Vitamins (Vitamin C, E, etc): type(s): _____
- Calcium: type: _____ amount: _____
- Herbs: type(s): _____
- Other: _____

Food Allergies/ Intolerances: _____

Please check (✓) everything below that describes your eating pattern and/or lifestyle behaviors:

1. I eat large portions, get seconds or overfill my plate	11. I don't take time to plan healthy meals ahead
2. I skip meals or go for longer than 5 hours between meals	12. I am tempted by family/friends to eat unhealthy foods
3. I dine out (includes carry-out) more than 3 times a week	13. I lack the knowledge to cook healthy
4. I frequently eat fried foods, fast foods and high fat foods	14. I never feel "full" or satisfied after eating
5. I frequently eat sweets and desserts (candy, cakes, cookies)	15. When dieting, I go to extremes
6. I graze (snack on food all day long while doing other things (reading, watching TV, computer work)	16. I drink less than 64 ounces (8 cups) daily (all fluids count)
7. I eat too quickly	17. I usually drink two or more alcoholic beverages daily
8. I am an emotional eater (I eat when I am stressed, bored, anxious...)	18. My work schedule hinders my weight loss efforts
9. I am so busy, I forget to stop and eat	19. I would have a difficult time reducing or giving up: _____
10. I am a "picky" eater	Other: _____