

Health Psychology Department

The purpose of this questionnaire is to assess your perception of your health and well-being. There are no right or wrong answers. You will have an opportunity to discuss concerns at your next appointment. Your answers will be held in strictest confidence and used for research purposes only. Please use black or blue ink.

Name: _____ Date: _____
Age: _____ Sex: _____
Address: _____ Phone: _____

How do you usually perceive your health? (Please check all that apply)

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Good |
| <input type="checkbox"/> Fair | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Very Poor | <input type="checkbox"/> Not at all |
| <input type="checkbox"/> Don't know | <input type="checkbox"/> Other (specify): _____ |

Psychological Status

How satisfied are you with your health? Yes No

If you were satisfied or neutral, we would like to see your feelings expressed. (Please explain)

What does your medical condition mean to you? Yes No

If you were negative:

Indicate whether or not any of the following things are important?

- _____ Health
_____ Appearance/Status
_____ Other things

Open-Ended

What else do you think? What else would you like to see? How long did you take to fill out this form?
