



<b>Alcohol and other intoxicants:</b>	
I use alcohol:	
<input type="checkbox"/> No	<input type="checkbox"/> Yes                      units per week (1 unit = 0,33 l medium strength beer / 12 cl wine / 4 cl spirits)
I use other intoxicants (e.g. drugs):	
<input type="checkbox"/> No	<input type="checkbox"/> Yes                      What?
I find it challenging to control my use of intoxicants or other addictions (e.g. drugs and gambling):	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
People close to me have been worried about some of the above:	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<b>Weight:</b>	<b>Height:</b>
<b>Housing:</b>	
<input type="checkbox"/> Apartment building	<input type="checkbox"/> Row house
<input type="checkbox"/> Detached house	<input type="checkbox"/> Service housing / assisted living
<input type="checkbox"/> Other, what?	
Describe your housing situation in more detail (e.g. do you live together with someone?):	
<b>Employment / livelihood:</b>	
<input type="checkbox"/> Student	<input type="checkbox"/> Employed
<input type="checkbox"/> Unemployed	<input type="checkbox"/> Retired
<input type="checkbox"/> Other, what?	
<input type="checkbox"/> On sick leave	<input type="checkbox"/> On rehabilitation allowance
<input type="checkbox"/> Specify period:	
<b>Hobbies and physical activity:</b>	
<b>Sleep:</b>	
I feel like I sleep well enough: <input type="checkbox"/> No <input type="checkbox"/> Yes	
<b>Need for assistance</b> (e.g. washing, cleaning, paying bills, shopping):	
<b>Assistive devices:</b>	
<input type="checkbox"/> No	<input type="checkbox"/> Yes, what?
<b>Legal guardianship:</b>	
<input type="checkbox"/> Not established	<input type="checkbox"/> Yes, but not in force for now
<input type="checkbox"/> Yes, in force	
More detailed information:	
<b>Driving license and firearm permit details:</b>	
Driving license	<input type="checkbox"/> No <input type="checkbox"/> Yes
Firearms permit	<input type="checkbox"/> No <input type="checkbox"/> Yes
License category:	
<b>Care guidelines and limitations:</b>	
Care guidelines and limitations	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> I don't know
More detailed information:	

**My own assessment of my condition and what I would like to change:**

**What brings joy to my life / helps me cope in everyday life:**

**Eating:**

I eat almost daily:  Breakfast  Lunch  Snack  Dinner  Supper

What is good about my eating habits:

Observations related to my eating habits (e.g. meal rhythm, nutritional variety, or challenges):

**Oral health:**

I have had an examination / check-up by an oral hygienist or dentist in the past two years (excluding emergency visits):

No  Yes

I have experienced physical (e.g. pain), psychological, or social harm related to oral or dental health in the past month:

No  Yes

**Most recent vaccinations:** (You can also bring vaccination information with you to the appointment)

**Completed/planned rehabilitation** (e.g. medical rehabilitation or rehabilitative psychotherapy):

**I would like to discuss the following topics with a professional** (e.g. physical activity, sexual health, everyday challenges):

