

Patient Name: _____ Date of Birth: _____ Date: _____

GENERAL HEALTH

How is your overall health?	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> I don't know
How many different prescriptions are you taking	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know
Do you take all of your medications as prescribed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Almost Never <input type="checkbox"/> I don't take medication
How is the health of your mouth and teeth?	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> I don't know
Do you have a dentist that you visit regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
How many times in the last six months have you been to the emergency room?	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know
How many times in the last six months were you admitted to the hospital?	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know

TOBACCO AND ALCOHOL USE

Do you use any tobacco products?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you interested in quitting tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't use tobacco
How many times in the past year have you had four or more alcoholic drinks in a day?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+
Are you interested in receiving help for any other type of substance abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't use other substances

NUTRITION

Has your food intake declined over the past 3 months?	<input type="checkbox"/> None <input type="checkbox"/> Some/moderate <input type="checkbox"/> A lot
How much weight have you lost in the past 3 months?	<input type="checkbox"/> 0-2lbs <input type="checkbox"/> 2-7lbs <input type="checkbox"/> 7+lbs <input type="checkbox"/> I don't know

PHYSICAL ACTIVITY

How many days a week do you exercise?	<input type="checkbox"/> None <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5+ <input type="checkbox"/> I don't know
On the days that you exercised, how long did you exercise?	<input type="checkbox"/> 0-30 min. <input type="checkbox"/> 30 min to 1 hr <input type="checkbox"/> More than 1 hr <input type="checkbox"/> I don't know <input type="checkbox"/> I don't exercise
How intense is your exercise?	<input type="checkbox"/> Light (stretching, slow walking) <input type="checkbox"/> Moderate (brisk walking) <input type="checkbox"/> Heavy (jogging, swimming) <input type="checkbox"/> Very heavy (running fast) <input type="checkbox"/> I don't know <input type="checkbox"/> I don't exercise

SLEEP

How many hours of sleep do you usually get?	<input type="checkbox"/> 0-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-10 <input type="checkbox"/> 10+ <input type="checkbox"/> I don't know
Do you snore or has anyone told you that you snore?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
In the past seven days, how often have you felt sleepy during the daytime?	<input type="checkbox"/> Often <input type="checkbox"/> Sometimes <input type="checkbox"/> Almost Never <input type="checkbox"/> Never <input type="checkbox"/> I don't know

ADVANCED DIRECTIVES

Do you have a health care power of attorney or a living will?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know
Would you like more information?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

FUNCTIONAL STATUS ASSESSMENT

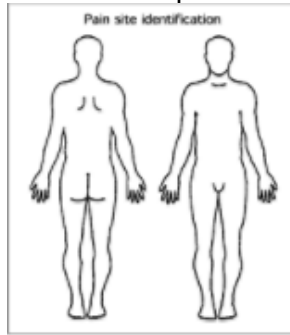
Instrumental activities of daily living			
Which of the following can you do on your own without help?	<input type="checkbox"/> Shop for groceries	<input type="checkbox"/> Drive/use public transport	
	<input type="checkbox"/> Use the telephone	<input type="checkbox"/> Make meals	
	<input type="checkbox"/> Housework	<input type="checkbox"/> Take medications	
	<input type="checkbox"/> Handle finances	<input type="checkbox"/> None	
Activities of Daily Living			
Which of the following can you do on your own without help?	<input type="checkbox"/> Bath	<input type="checkbox"/> Dress	<input type="checkbox"/> Eat
	<input type="checkbox"/> Walk	<input type="checkbox"/> Transfer (in/out of chairs, etc)	<input type="checkbox"/> Use restroom
		<input type="checkbox"/> None	
Many people experience leakage of urine, also called urinary incontinence. In the past six months, have you experienced leaking of urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know
Ambulation status			
How long can you walk or move around?	<input type="checkbox"/> 0-5 min.	<input type="checkbox"/> 5-15 min.	<input type="checkbox"/> 15-30 min.
	<input type="checkbox"/> More than 1 hr	<input type="checkbox"/> I don't know	
Which of these assistive devices do you use?	<input type="checkbox"/> Cane	<input type="checkbox"/> Walker	<input type="checkbox"/> Wheelchair
	<input type="checkbox"/> Crutches	<input type="checkbox"/> Other	<input type="checkbox"/> None
Do you have trouble with your balance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you fallen in the last six months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sensory Ability			
Do you have problems with vision?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know
Do you have eyeglasses or contact lenses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know
Do you have problems with hearing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know
Do you use hearing aids or other devices to help you hear?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know

PAIN ASSESSMENT

In the past two weeks, how often have you felt pain?

- Almost all the time
- Most times
- Sometimes
- Almost Never
- No Pain

Where is the pain?

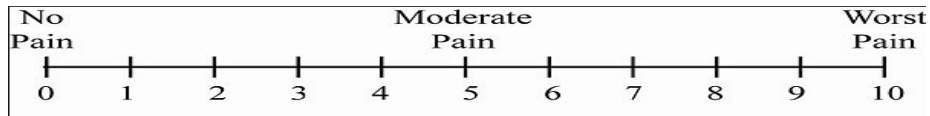


No Pain **OR** Mark all areas indicated

How do you treat pain?

- Medication
- Rest
- Heat or Cold
- Therapy
- Other
- No treatment plan
- No Pain

Rate your pain on a scale of 0-10 with 0 being NO pain and 10 being the worst pain:



HOME/SAFETY

What is your living situation?

- Alone
- With my spouse or other family member
- With a friend or roommate
- In a nursing home or assisted living
- I don't have a place to live
- Other

Does your home have working smoke alarms?

- Yes No I don't know

Do you fasten your seatbelt in vehicles?

- Yes No I don't know

PHQ-9

In the last two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

- Not at all Several Days
 More than half the days Nearly every day
 I don't know

Feeling down, depressed or hopeless

- Not at all Several Days
 More than half the days Nearly every day
 I don't know

Trouble falling or staying asleep or sleeping too much

- Not at all Several Days
 More than half the days Nearly every day
 I don't know

Feeling tired or having little energy

- Not at all Several Days
 More than half the days Nearly every day
 I don't know

Poor Appetite or overeating	<input type="checkbox"/> Not at all <input type="checkbox"/> More than half the days <input type="checkbox"/> I don't know	<input type="checkbox"/> Several Days <input type="checkbox"/> Nearly every day
Feeling bad about yourself or that you're a failure or have let yourself or your family down	<input type="checkbox"/> Not at all <input type="checkbox"/> More than half the days <input type="checkbox"/> I don't know	<input type="checkbox"/> Several Days <input type="checkbox"/> Nearly every day
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> Not at all <input type="checkbox"/> More than half the days <input type="checkbox"/> I don't know	<input type="checkbox"/> Several Days <input type="checkbox"/> Nearly every day
Moving or speaking so slowly that other people could have noticed. Or the opposite – being fidgety or restless that you've been moving around a lot more than usual.	<input type="checkbox"/> Not at all <input type="checkbox"/> More than half the days <input type="checkbox"/> I don't know	<input type="checkbox"/> Several Days <input type="checkbox"/> Nearly every day
Thoughts that you would be better off dead or of hurting yourself	<input type="checkbox"/> Not at all <input type="checkbox"/> More than half the days <input type="checkbox"/> I don't know	<input type="checkbox"/> Several Days <input type="checkbox"/> Nearly every day
If you checked any of the problems in this section, how difficult have these problems make it for you to do your work, take care of things at home, or get along with other people?	<input type="checkbox"/> Not at all <input type="checkbox"/> More than half the days <input type="checkbox"/> I don't know	<input type="checkbox"/> Several Days <input type="checkbox"/> Nearly every day

Mini-Cog

Please draw a clock showing 11:10

OFFICIAL USE ONLY

Patient Signature: _____ Date Completed: _____

Clinician Signature: _____ Date Completed: _____

The AWV and HRA were completed today. This included the following topics: General health, Tobacco/Alcohol use, Nutrition, Physical activity, Sleep, Advance Directive and Living Will information offered to patient, ADLS, Fall risk assessment, Pain risk assessment, Home safety and Depression-PHQ-9 completed and reviewed.