Date: ________ **Name:**___________________________________ **Ht:**_____ **Wt:**_______ **BMI:** _____ **BP:**___________

This assessment is designed to provide us with some important health and health related information. The information we receive in the assessment helps us understand your unique health and health related problems, and develop appropriate measures to assist you in maintaining your health and well-being. We ask that you please complete all sections of the assessment. Thank you

How would you rate your personal health at the present time? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Compared to one year ago, how would you rate your health? ☐ Better ☐ About the same ☐ Worse

Living Situation – Live alone ☐ Yes ☐ No - Who lives with you? Name _________ Relationship ___________

Barriers to Care – Do you have any problems getting care you need because of any of the following reasons?

☐ Transportation ☐ Financial ☐ Physical Limitations ☐ Language ☐ Support system ☐ Other________

Are you currently taking an aspirin regiment? ☐ Yes ☐ No ☐ Contraindicated: ___________

Specialist	Name	Specialist	Name	Specialist	Name
Cardiologist	________________	Gastro	_________________	Opthalmology	_________________
Ortho	________________	Neuro	_________________	Other	_________________

Nutritional Assessment

☐ Water intake: ____/oz daily ☐ Other: _____________________

☐ high in fiber ☐ high in protein ☐ high in carbohydrates ☐ high in fat ☐ high in sugar.

Level of Activity

☐ No exercise ☐ Light exercise ☐ Moderate exercise ☐ Strenuous exercise Frequency: __________________

Type of activity :(aerobics, cycling, dancing, running, stair machine, swimming, walking):________________________

FUNCTIONAL STATUS ASSESSMENT

Cognitive: Oriented ☐ x1 person ☐ x2 person/place ☐ x3 person/place/time

Ambulatory: ☐ Independent ☐ Walks with aid ☐ Wheelchair bound

Activities of Daily Living:	**Yes**	**REQ. ASSISTANCE**	**No**
Grooming:	☐	☐	☐
Dressing:	☐	☐	☐
Toileting:	☐	☐	☐
Food Prep:	☐	☐	☐
Eating:	☐	☐	☐
Transferring:	☐	☐	☐
Bathing:	☐	☐	☐
Medication Admin:	☐	☐	☐
Finances	☐	☐	☐

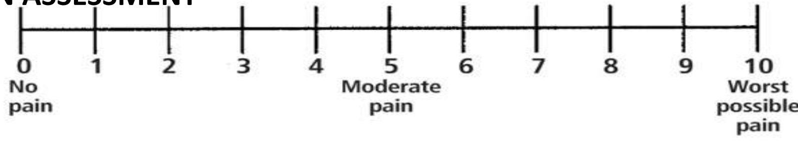
HOME SAFETY ASSESSMENT **Does your house have:**

Good Lighting ☐ Yes ☐ No Non-Slip surfaces in bath ☐ Yes ☐ No Grab bars in shower ☐ Yes ☐ No

Functioning Smoke alarm ☐ Yes ☐ No Handrails on Stairs ☐ Yes No Non-slip rugs ☐ Yes ☐ No

Date: ________ Name:___________________________________ Ht:_____ Wt:_______ BMI: _____ BP:___________

PAIN ASSESSMENT



Location:_______________________________

Controlled with?_________________________

How long? ______________________________

Do you see a pain management specialist? ☐ No ☐ Yes; Who? --> **Dr.**___________________________________

ADVANCED DIRECTIVES- Do you have an "Advanced Directive" of any kind?

☐ No ☐ Yes; What is it? ☐ Living Will ☐ Power of Attorney ☐ Healthcare Proxy/Surrogate

Healthcare surrogate: _______________________________ (Write name in case of emergency)

If you would like to be provided with information regarding advanced directive please let staff know.

TOBACCO USE ASSESSMENT (Answer both lines)

☐ Never Smoked ☐ Former Smoker (Quit:_______) ☐ Current Smoker (Cigarette/Cigar: #____/day x Years _____)

☐ Tobacco Smoke ☐ Smokeless Tobacco User (Can/Pouch:# ___/day)

ASSESS ALCOHOL USE & SCREEN

☐ No Alcohol Use (Non-Drinker) ☐ Yes →*Continue to questions 1-3 below:*

1. How often do you have drinks containing alcohol? ___________________
2. How many drinks containing alcohol do you have on a typical day of drinking? ___________________
3. How often do you have 5 or more drinks on one occasion? ___________________

DEPRESSION SCREENING (PHQ-9) Over the last 2 weeks, how often have you been bothered by any of the following:	Not at all (0)	Several days (1)	More than 7 days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things?	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless?	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much?	☐	☐	☐	☐
4. Feeling tired or having little energy?	☐	☐	☐	☐
5. Poor appetite or overeating?	☐	☐	☐	☐
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down?	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way?	☐	☐	☐	☐

Check if applicable: ☐ Bipolar disorder ☐ Active dx of depression ☐ MDD in remission ☐ Delirium

Are you currently taking an anti-depressant? ☐ Yes; What? __________________ ☐ No

Name of psychiatrist/psychologist, if being seen: ____

Management of Urinary Incontinence in Older Adults

In the past 6 months, have you accidently leaked urine? ☐ Yes (continue to 1-3 below) ☐ No

1. How much of a problem, if any, was the urine leakage for you?
   ☐ Not a problem ☐ A small problem ☐ A big problem
2. Have you talked with your current doctor or health provider about your urine leakage problem? ☐ Yes ☐ No
3. There are many ways to treat urinary incontinence including bladder training exercises, medications and surgery. Have you received these or any other treatments for your current urine leakage problems? ☐ Yes ☐ No

Date: ________ Name:___________________________________ Ht:_____ Wt:_______ BMI: _____ BP:___________

Health Conditions

Please indicate if you currently have or have had the following health conditions or problems (√ all that apply)

☐ Bladder/Kidney problems ☐ COPD/Emphysema ☐ Stroke ☐ Heart Problems (CHF, MI, etc)
☐ Arthritis ☐ Cancer ☐ Diabetes ☐ Incontinence (Bladder/Bowel)
☐ Osteoporosis ☐ Depression ☐ Paralysis

Other Health Conditions or problems: ____

Special Services

Please indicate whether you currently receive any of the following special services (√ all that apply)

☐ Physical Therapy ☐ Occupational Therapy ☐ Respiratory Therapy ☐ Dialysis
☐ Catheter Care ☐ Insulin pump Therapy ☐ Bowel/Bladder Rehab
☐ Speech Therapy ☐ Wound Care ☐ Oxygen Therapy

Medication Adherence : Below is a list of problems that people sometimes have with their medicines. Please check how hard it is for you to do each of the following:

	Very hard	Somewhat hard	Not hard at all
Open or close the medicine bottle	________	_________	________
Read the print on the bottle	________	_________	________
Remember to take the pills	________	_________	________
Take so many pills at the same time	________	_________	________

Hospital and Emergency Room Visits

In the past 12 months, how many times have you:

Gone to the Emergency Room ☐ 0 ☐ 1 ☐ 2 ☐ 3 or more times
Stayed overnight in a hospital ☐ 0 ☐ 1 ☐ 2 ☐ 3 or more times

Medical/Surgical History- Update

SPECIALIST & MEDICAL HISTORY- UPDATE (surgeries, hospitalizations, new diagnoses)

____

____

Hearing Screening (COMPLETE W/NURSE)

Do you have any concerns about your hearing? ☐ No ☐ Yes – Refer to Audiology at Pt. request
Do you wear hearing aids? ☐ None ☐ Left ☐ Right ☐ Both
☐ Able to hear watch ticking ☐ Able to hear whisper ☐ Able to hear finger rubbing together

Visual Acuity (COMPLETE W/NURSE)

Do you wear glasses or contact lenses? ☐ None ☐ Glasses ☐ Contact Lenses
Visual Acuity Right Eye ___/___ Left Eye ___/___ Both eyes___/___

Have you been taking any of the following for **at least 6 months? (COMPLETE W/NURSE)**

☐ Digoxin ☐ Diuretic ☐ ACE/ARB ☐ Anticonvulsant ☐ Beta-Blocker ☐ Statin

Date: ________ Name:___________________________________ Ht:_____ Wt:_______ BMI: _____ BP:___________

Clinical staff to complete

Health Screenings	Date last performed	Due
Flu Vaccine	__________________	______
Pneumovax 23	__________________	______
Prevnar 13	__________________	______
Mammogram	__________________	______
Pap Smear	__________________	______
Dexa	__________________	______
Colonoscopy Every 9 years OR	__________________	______
Urine Microalbumin	__________________	______

Health Screenings	Date last performed	Due
Diabetic Eye exam If patient is Diabetic OR	_________________	_______
Glaucoma Screening For Non-Diabetic patients	_________________	_______
Diabetic Foot Exam	_________________	_______
HbA1C	_________________	_______
PSA	_________________	_______
FOBT every year	________________	______

Date: ________ Name:__________________________________ Ht:_____ Wt:_______ BMI: _____ BP:___________

COMPLETE THIS PAGE ONCE YOU ARE IN THE EXAM ROOM

Mini-Mental Status Exam (MMSE)

PLEASE COMPLETE THE ORIENTATION, LOCATION & LANGUAGE PORTIONS

Orientation (Completed by Patient)

__ / 5 What is the current:
Date: ________ Year: _____ Month: _______
Day of the week today: ______Season: _______

Location (Completed by Patient)

__ / 5 Where are you?
State: ________ City: _______ Country: _____
Current Facility: ______ Type of rooms: ______

Registration & Recall (COMPLETE W/NURSE)

What 3 items were you asked to remember?

__ / 2 1. ________________ Recall ______________

__/ 2 2.________________ Recall ______________

__/ 2 3.________________ Recall______________

Attention and Calculation (COMPLETE W/NURSE)

__ / 5 Spell the given word backwards:

____

Memory Recall (COMPLETE W/NURSE)

__/1 Memory recall – Pencil
__/1 Memory recall – Wrist Watch

Patient repeats: "No ifs, ands or butts"
__/1 Phrase repeated back correctly

Language (COMPLETE W/NURSE)

__/1 Read words on page and do what is says
CLOSE YOUR EYES

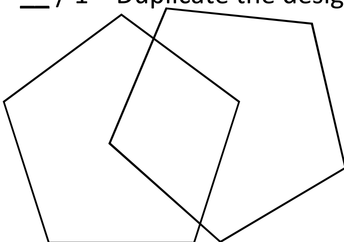
Completed by Patient

__ / 1 Write a complete sentence on line below:
Should contain a subject, a verb & sensible. That's all.

____

__/3 Follow 3-step verbal command

__ / 1 Duplicate the design shown below



Fall Risk Assessment (Completed by Patient)

Have you had any falls in the past year?

- ☐ No falls in the past year
- ☐ One fall in the past year but WITHOUT injury
- ☐ Any fall in the past year WITH an injury
- ☐ Two or more falls in the past year

____History of falls in the last 3 months?

☐ No ☐ Yes

____Use of Ambulatory Aid?

- ☐ Walks without walking aid/uses wheelchair/ bedrest
- ☐ Uses crutches, walker or a cane
- ☐ Walks clutching onto furniture for support

____ IV or Heparin / Saline Lock?

- ☐ Patient doesn't have IV, heparin (saline) lock
- ☐ Patient has an IV, heparin (saline) lock, monitoring equipment, Foley catheter

____ Gait Transferring

- ☐ Walks w/head erect, arms swing freely, strides without hesitation
- ☐ Stooped head, short steps, furniture may be touched as guide
- ☐ Difficulty rising from chair (needs to use arms/several attempts), head down; watches ground while walking, short shuffling gait

Wheelchair: score according to gait used at transfer

Secondary Diagnosis

☐ None	☐ Impaired mobility
☐ use of assistive devices	☐ Dementia
☐ Muscle weakness	☐ Adv. Age >80
☐ Impaired activity daily living	☐ Arthritis
☐ previous falls (past 24 mths)	☐ Depression
☐ special toileting needs	☐ Balance Deficit