

Name: _____ **Date:** _____ **MR#:** _____

Date of Birth: _____ **Age:** _____

YES **NO**

1. Have you had any problems with balance or walking?..... YES NO
2. Do you have numbness, tingling, or burning in your hands or feet?..... YES NO
3. Are you physically active? (ex: Walking, Group Classes, Stationary Bike)..... YES NO
 - How many times per week do you get exercise? _____
4. Have you fallen in the last 3 months?..... YES NO

(A fall is when your body goes to the ground without being pushed)

 - How many times? _____
 - Were you using an assistive device? (ex: Cane, Walker, Wheelchair)..... YES NO
 - Date the last fall occurred? _____

Circumstances of the fall

- a) Tripped / Stumbled over something..... YES NO
- b) Lightheadedness / Pounding heart rate..... YES NO
- c) Unable to get up within 5 minutes..... YES NO
- d) Needed assistance to get up..... YES NO
- e) Loss of consciousness..... YES NO
- f) Were you seen in the emergency department?..... YES NO
5. Do you have a device for mobility?..... YES NO

Please circle all that apply: Cane Walker Wheelchair Other: _____

6. Any recent vision changes?..... YES NO
7. Any recent hearing changes?..... YES NO
8. Many people experience problems with urinary incontinence, the leakage of urine,
have you had problems with urine leakage?..... YES NO







Well Being Assessment

- | | YES | NO |
|--|-----------------------|-----------------------|
| 9. Have you had any problems with your short-term memory?.....
Ex: What did you have for dinner last night? | <input type="radio"/> | <input type="radio"/> |
| 10. Have you had any problems with your long-term memory?.....
Ex: Where were you born? | <input type="radio"/> | <input type="radio"/> |
| 11. Over the past two weeks have you felt down, depressed, or hopeless?..... | <input type="radio"/> | <input type="radio"/> |
| 12. Over the past two weeks have you felt little interest or pleasure in doing things?..... | <input type="radio"/> | <input type="radio"/> |
| 13. Do you have an Advanced Directive or Living Will? *If YES please bring in a copy..... | <input type="radio"/> | <input type="radio"/> |
| 14. Are you being physically or psychologically abused at home?..... | <input type="radio"/> | <input type="radio"/> |
| 15. Do you drink alcohol?..... | <input type="radio"/> | <input type="radio"/> |
| • How many drinks per day? _____ Per week? _____ | | |

16. Do you have any problems completing the following activities?

Activity	You can do this by yourself	You need help	Someone else must do this for you
Bathing			
Getting Dressed			
Getting to and from the toilet			
Shopping			
Preparing Meals			
Feeding Self			
Using the telephone			
Housekeeping			
Laundry			
Managing Medications			
Managing Household Finances			

17. Please Circle the number that best describes your overall pain level

0	1	2	3	4	5	6	7	8	9	10
NO Pain	Mild Pain	Moderate Pain	Severe Pain	Very Severe	Worst Possible					
										

Well Being Assessment

18. How would you rate your overall health? **(Please Circle One)** Poor Fair Good Excellent

To be completed by the Medical Assistant

19. Last Flu Shot (mm/yyyy): _____ Last Pneumonia Shot (mm/yyyy): _____

20. If answered YES to question 4a, b, or e, check orthostatics: (Measure at least 1 minute in specified position)

Lying BP: _____ / _____ Pulse: _____

Sitting BP: _____ / _____ Pulse: _____

Standing BP: _____ / _____ Pulse: _____

Have there been any new medications started around the time of this fall? _____

21. Get up and Go: _____ sec.

(Stand from chair, walk 10ft., turn around walk back, sit down)

Abnormal if: >12 sec, hesitant start, broad-based gait, path deviates, and/or unbalanced gait.

22. Make sure eye exam on chart once a year or if answer to #6 above is YES

OS: 20/____ OD: 20/____ OU: 20/____

23. If answered YES to questions 9 or 10 please complete Mini-Cog test form.

24. If answered YES to questions 11 or 12 please complete PHQ-9 form.

Notes:

Patient Name: _____ MRN#: _____ Date: _____