Well Being Assessment

Name: ______________________________ **Date:** ________________ **MR#:** ________________

Date of Birth: ________________________ **Age:** ________________

	YES	NO
1. Have you had any problems with balance or walking?............	◯	◯
2. Are you physically active? (ex: Walking, Group Classes, Stationary Bike)	◯	◯
• How many times per week do you get exercise? ____________		
3. Have you fallen in the last 3 months?	◯	◯
(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)	◯	◯
• Date the last fall occurred? __________________		
Circumstances of the fall		
a. Tripped / Stumbled over something............	◯	◯
b. Lightheadedness / Pounding Heart Rate............	◯	◯
c. Unable to get up within 5 minutes............	◯	◯
d. Needed assistance to get up............	◯	◯
e. Loss of Consciousness............	◯	◯
f. Were you seen in the emergency department?	◯	◯
4. Do you have a device for mobility?	◯	◯
Please Circle: Cane Walker Wheelchair Other: ____________		
5. Any recent vision changes?	◯	◯
6. Any recent hearing changes?............	◯	◯
7. Many people experience problems with urinary incontinence, the leakage of urine, have you had problems with urine leakage?............	◯	◯
8. Have you had any problems with your short-term memory? .... ex: What did you have for dinner last night?	◯	◯
9. Have you had any problems with your long-term memory?............ ex: Where were you born?	◯	◯
10. Over the past two weeks have you felt down, depressed, or hopeless?............	◯	◯
11. Over the past two weeks have you felt little interest or pleasure in doing things?............	◯	◯
12. Do you have an Advanced Directive or Living Will? *If YES please bring in a copy............	◯	◯

Well Being Assessment

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

	You can do this By Yourself.	You Need Help	Someone else must do it for you
Bathing			
Getting Dressed			
Getting to and from the toliet			
Shopping			
Preparing Meals			
Feeding Self			
Using the telephone			
Housekeeping			
Laundry			
Managing Medications			
Managing Household Finances			

14. Please Circle the number the 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

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

---

To be completed by the Medical Assistant

16. Last Flu Shot (mm/yyyy): ______________________ Last Pneumonia Shot (mm/yyyy): ______________________

17. If yes to 3 a,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? ________________________________

18. Get up and Go: ______ sec.

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

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

19. Make sure eye exam on chart once a year or if answer to #5 above is YES

OS: 20/_____ OD: 20/_____ OU: 20/_____

20. If answer to questions 8 or 9 is YES please complete MMSE form

21. If answer to question 10 or 11 is YES please complete PHQ-9 form

Notes:

Patient Name: ______________________ MRN#: ______________ Date: ______________