HealthCare Partners Nevada
an Intermountain Healthcare company

Well Being Assessment

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

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

	YES	NO
1. Have you had any problems with balance or walking?	◯	◯
2. Do you have numbness, tingling, or burning in your hands or feet?	◯	◯
3. Are you physically active? (ex: Walking, Group Classes, Stationary Bike)	◯	◯
• How many times per week do you get exercise? _____		
4. 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?	◯	◯
5. Do you have a device for mobility?	◯	◯
Please circle all that apply: Cane Walker Wheelchair Other:_____		
6. Any recent vision changes?	◯	◯
7. Any recent hearing changes?	◯	◯
8. Many people experience problems with urinary incontinence, the leakage of urine, have you had problems with urine leakage?	◯	◯

	YES	NO
9. Have you had any problems with your short-term memory?.....	◯	◯
Ex: What did you have for dinner last night?		
10. Have you had any problems with your long-term memory?.....	◯	◯
Ex: Where were you born?		
11. Over the past two weeks have you felt down, depressed, or hopeless?.....	◯	◯
12. Over the past two weeks have you felt little interest or pleasure in doing things?.....	◯	◯
13. Do you have an Advanced Directive or Living Will? *If YES please bring in a copy.....	◯	◯
14. Are you being physically or psychologically abused at home?.....	◯	◯
15. Do you drink alcohol?.....	◯	◯

- 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

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: _____