Patient Name: ____ DOB: ____________________

In general, how would you rate your overall health?

Excellent	Good	Poor

In general, how would you rate your overall emotional or mental health?

Excellent	Good	Poor

Do you have trouble hearing?

NO
Yes, but it doesn't bother me or others
Yes, and it is an issue for me or others

Are you able to perform day to day tasks without assistance?

Yes	No

Which of the following do you need assistance with?

Grooming	Getting dressed	Bathing	Using the toilet	Eating
Doing laundry	Housekeeping	Shopping	Preparing meals	Using the telephone
Managing money				

Because of physical/mental/emotional conditions, do you have difficulty concentrating, remembering or making decisions?

Yes	No

Do you have excessive worry or stress in your life?

Yes	No

Where do you live?

Apartment	Assisted living	House
Nursing home	Senior living facility	Trailer

Patient Name: ____ DOB: ______________________

Do you feel safe at home?

Yes	No

Who would help you if you became ill or injured?

Caregiver	Children	Friend	Neighbors
NONE	Other family member	Spouse	

Do you have smoke detectors?

Yes	No

Do you have safety bars in the bathroom?

Yes	No

Do you ever take your medications for reasons other than wheat they are prescribed for?

Yes	No

Would your family feel safe riding in a car if you're driving?

Yes	No

How many times have you fallen in the past year? Where you injured?

No falls in the past year
1 fall in the past year – no injury
1 fall in the past year – injured
2 or more falls in the past year – no injury
2 or more falls in the past year – injured
Not ambulatory

Do you feel unsteady or wobbly when standing or walking?

Yes	No

Patient Name: ____ DOB: ______________________

Do you worry about falling?

Yes	No

If recommended to use a cane or a walker, do you use it consistently?

Yes	No

Are you generally able to eat well?

Yes	No

If you are NOT generally able to eat well, which issues prevent you from eating well?

Difficulty chewing	Trouble swallowing	Poor appetite	Illness	Financial problems

Have you lost or gained weight without trying in the last year?

Yes	No

Do you consider your diet to be healthy?

Healthy	Portions too big	Too much sugar	Too much fat

Do you participate in activities to increase your heart rate at least several days a week?

Yes	No

Do you participate in strength building activities at least twice per week?

Yes	No

Do you smoke?

Yes	No

Patient Name: ____ DOB: ____________________

MEN: do you consume more than 2 servings of alcohol per day?

Yes	No

WOMEN: Do you consume more than 1 servings of alcohol a day?

Yes	No

In the event of a terminal illness, would you prefer aggressive treatment or comfort care only?

Aggressive	Comfort

In the event of brain death, would you prefer aggressive treatment or comfort care only?

Aggressive	Comfort

Do you have advanced directive documents?

No	Living will	Medical Power of Attorney	Out of Hospital DNR	Scope of Treatment

Please list all specialists / doctors that you receive care from:

Provider Name	Specialty	Phone/Address

Patient Name: ____ DOB: ______________________

What is your living situation today?

I have a steady place to live	I DO NOT have a steady place to live

Who lives with you?

Alone	Caregiver	Children	Family members	Father	Friend
Friends	Grandparents	Legal guardian	Mother	Parents	Significant other
Spouse or partner					

Support system

Case manager	Children	Faith based	Family	Friends
Home care staff	Legal guardian	Neighbors	Parents	Partner
Shelter	Significant other	Social worker	Spouse	Therapist
Twelve step group	None			

Who would help you if you became ill or injured?

Caregiver	Children	Family	Father	Friend
Grandparent	Legal guardian	Mother	Parent	Significant other
Spouse or partner	None			

Are you lonely most days?

YES / NO

Does anyone, including family, bully you, insult you, talk down to you, scream or curse at you, threaten you with harm, or physically hurt you?

YES / NO

What keeps you from being healthier?

Transportation	Food	Unable to exercise	Not motivated	Inadequate insurance
Not enough time	Cost of medications	Child care	Utilities	No Barriers

Do you wear seat belts?

YES / NO

Do you ride a motorcycle of bicycle?

YES / NO

Do you wear a helmet?

YES / NO