

PAIN ASSESSMENT		
If any pain within the past 7 days, describe the type of pain and location: Check all that apply: <input type="checkbox"/> Head <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis <input type="checkbox"/> Neck	Check all that apply: <input type="checkbox"/> Mid Back <input type="checkbox"/> Lower Back <input type="checkbox"/> Right Upper Extremity <input type="checkbox"/> Left Upper Extremity <input type="checkbox"/> Right Lower Extremity <input type="checkbox"/> Left Lower Extremity	Select the number that best describes the pain level <input type="radio"/> 0 – nothing hurts <input type="radio"/> 2 – hurts a little <input type="radio"/> 4 – hurts a little more <input type="radio"/> 6 – hurts even more <input type="radio"/> 8 – hurts a whole lot <input type="radio"/> 10 – hurts worst

ACTIVITIES OF DAILY LIVING (ADL)			
Activity		YES (Abnormal)	NO (Normal)
CONTINENCE	YES = incontinent (or catheterized and unable to manage alone) NO = independent	<input type="radio"/>	<input type="radio"/>
MOBILITY/TRANSFERRING	YES = unable, needs help in moving from bed to chair or requires complete transfer, uses wheelchair NO = moves in and out of bed unassisted (mechanical aids are acceptable)	<input type="radio"/>	<input type="radio"/>
EATING	YES = needs partial or total help with eating or requires parenteral feeding NO = gets food from plate into mouth independently (prep of food may be done by another person)	<input type="radio"/>	<input type="radio"/>
BATHING	YES = needs help with bathing or getting in and out of the shower NO = independent (bathes self completely, disabled extremity)	<input type="radio"/>	<input type="radio"/>
DRESSING	YES = needs help with dressing self or needs to be completely dressed NO = gets clothes from closet and puts on clothes complete with fasteners	<input type="radio"/>	<input type="radio"/>
TOILET USE	YES = needs help transferring to the toilet, unable to clean self, uses bed pan or commode NO = goes to toilet, gets on and off, cleans genital area without help	<input type="radio"/>	<input type="radio"/>
WALKING	YES = Needs help from another person with walking or completely unable to walk NO = Independent (able to walk by themselves or cane or other assistive devices)	<input type="radio"/>	<input type="radio"/>
HOUSEWORK, HOME REPAIR, LAUNDRY, MEAL PREPARATION	YES = Unable to perform tasks NO = Independent (able to perform tasks independently or with just minimal assistance)	<input type="radio"/>	<input type="radio"/>
TRANSPORTATION	YES = Unable to drive or use public transportation NO = Independent (able to drive or use public transportation)	<input type="radio"/>	<input type="radio"/>
MEDICATIONS	YES = Unable to handle their own medications NO = Independent (able to handle medications independently or with just minimal assistance)	<input type="radio"/>	<input type="radio"/>
FINANCES	YES = Unable to handle their own finances NO = Independent (can handle their own finances independently or with just minimal assistance)	<input type="radio"/>	<input type="radio"/>

HOME HEALTH SCREEN	YES (Abnormal)	NO (Normal)	N/A
Have you fallen AT ANY TIME within the last 12 months?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If you fell, did you fall more than once?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If you fell, did you get injured?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Home has throw rugs, poor lighting or slippery bathtub/shower?	<input type="radio"/>	<input type="radio"/>	
Home lacks grab bars in bathroom or lacks handrails on stairs?	<input type="radio"/>	<input type="radio"/>	
Home has no functioning smoke alarms?	<input type="radio"/>	<input type="radio"/>	

URINARY INCONTINENCE ASSESSMENT (Age 65+)	YES (Abnormal)	NO (Normal)	N/A
In the past 6 months, have you accidentally leaked urine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If yes, was the urine leakage a problem for you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did leaking of urine make you change your daily activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did leaking of urine interfere with your sleep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ADVANCED CARE PLANNING		
Check all that apply Do you have: <input type="radio"/> Advance Directives <input type="radio"/> Living Will <input type="radio"/> Surrogate Decision Maker <input type="radio"/> Actionable Medical Orders <input type="radio"/> None of the Above	Patient/caregiver desires Advanced Care Planning?? <input type="radio"/> Yes <input type="radio"/> No You have given a copy to your Provider? <input type="radio"/> Yes <input type="radio"/> No	

RISK ASSESSMENT

<p>1. In general, would you say your health is?</p> <p><input type="radio"/> Good</p> <p><input type="radio"/> Fair</p> <p><input type="radio"/> Poor</p>	<p>2. In the past 7 days, how often did you exercise for at least 20 minutes in a day?</p> <p><input type="radio"/> More than 4 days</p> <p><input type="radio"/> 2 - 4 days</p> <p><input type="radio"/> Not At All</p> <p>Exercise includes walking, housekeeping, jogging, weights, a sport or playing with your kids. It can be done on the job, around the house, just for fun or as a work-out.</p>	<p>3. How intense was your exercise?</p> <p><input type="radio"/> Heavy (like fast running, jogging, stair climbing, swimming)</p> <p><input type="radio"/> Moderate to light (like walking, stretching)</p> <p><input type="radio"/> Not currently exercising</p>
<p>4. In the past 7 days, how often did you eat 1 or more servings of fruits or vegetables in a day?</p> <p><input type="radio"/> More than 4 days</p> <p><input type="radio"/> 2 - 4 days</p> <p><input type="radio"/> Not At All</p>	<p>5. In the past 7 days, how often did you eat 1 or more servings of high fiber or whole grain foods in a day?</p> <p><input type="radio"/> More than 4 days</p> <p><input type="radio"/> 2 - 4 days</p> <p><input type="radio"/> Not At All</p>	<p>6. In the past 7 days, how often did you eat 1 or more servings of fried or high fat foods in a day?</p> <p><input type="radio"/> More than 4 days</p> <p><input type="radio"/> 2 - 4 days</p> <p><input type="radio"/> Not At All</p>
<p>7. In the past 7 days, how often did you eat 1 or more servings of sugar-sweetened (not diet) beverages in a day?</p> <p><input type="radio"/> More than 4 days</p> <p><input type="radio"/> 2 - 4 days</p> <p><input type="radio"/> Not At All</p>	<p>8. In the past 7 days, how often did you have (5 or more for men, 4 or more for women) alcoholic drinks at one time?</p> <p><input type="radio"/> Not At All</p> <p><input type="radio"/> 2 - 4 days</p> <p><input type="radio"/> More than 4 days</p>	<p>9. Do you ever drive after drinking or ride with a driver who has been drinking?</p> <p><input type="radio"/> Yes</p> <p><input type="radio"/> No</p> <p><input type="radio"/> Not Sure</p>
<p>10. In the past 2 weeks, how often have you felt tense, anxious or on edge?</p> <p><input type="radio"/> Almost never</p> <p><input type="radio"/> Some of the time</p> <p><input type="radio"/> Most of the time</p>	<p>11. In the past 2 weeks, how often were you <u>not</u> able to stop worrying or control your worrying?</p> <p><input type="radio"/> Almost never</p> <p><input type="radio"/> Some of the time</p> <p><input type="radio"/> Most of the time</p>	<p>12. How often is stress a problem for you in handling such things as your health, finances, family or social relationships, work?</p> <p><input type="radio"/> Never or rarely</p> <p><input type="radio"/> Some of the time</p> <p><input type="radio"/> Most of the time</p>
<p>13. How often do you get the social and emotional support you need?</p> <p><input type="radio"/> Almost Always</p> <p><input type="radio"/> Rarely</p> <p><input type="radio"/> Never</p>	<p>14. How would you describe the condition of your mouth and teeth (including false teeth or dentures)?</p> <p><input type="radio"/> Good</p> <p><input type="radio"/> Fair</p> <p><input type="radio"/> Poor</p>	<p>15. Each night, how many hours of sleep do you get?</p> <p><input type="radio"/> At least 8</p> <p><input type="radio"/> 4-7</p> <p><input type="radio"/> Less than 4</p>
<p>16. Do you snore, or has anyone told you that you snore?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not sure</p>	<p>17. How often have you felt sleepy, in the past 7 days?</p> <p><input type="radio"/> Often</p> <p><input type="radio"/> Sometimes</p> <p><input type="radio"/> Never</p>	<p>18. Do you always fasten your seat belt when you're in a car?</p> <p><input type="radio"/> Always</p> <p><input type="radio"/> Usually</p> <p><input type="radio"/> Never</p>
<p>19. Are you aware of your results for tests performed in the past year; such as Blood Pressure, Cholesterol, Blood Glucose, Hemoglobin A1c?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not sure</p>		