Date:	Legal Name: Last First Middle	Date of birth:

Annual Wellness Assessment

Please mark the appropriate response

End of Life Planning:

1. Do you have an Advance Directive?
   - Yes, on file
   - Yes, not on file
   - No
2. If not, would you like further information on Advance Directives?
   - Yes
   - No
3. Would you like to discuss your wishes regarding end of life care at the time of your next visit?
   - Yes
   - No

Hearing and Vision:

1. Do you find yourself asking people to repeat themselves?
   - Yes
   - No
2. Do you have difficulty hearing?
   - Yes
   - No
3. Do you feel that a vision difficulty limits your personal life?
   - Yes
   - No

Functional Assessment:

1. Do you need help performing any of the following tasks? **Check those you need help with**.
   - Using the telephone
   - Eating/ Bathing/ Dressing
   - Getting places by bus/taxi/driving
   - Taking medications
   - Getting around your home
   - Managing money
   - Grocery shopping
   - Housework
2. Do you have any concerns regarding changes in your memory or cognitive ability?
   - Yes
   - No

Pain/Fatigue:

1. Do you have pain that interferes with your desired activities?
   - Yes
   - No
2. Do you often feel tired or fatigue?
   - Yes
   - No

Fall Risk:

1. Have you fallen 2 or more times in the past year?
   - Yes
   - No
2. Do you feel dizzy when you get up from a bed or chair?
   - Yes
   - No
3. Do you feel unsteady when you walk?
   - Yes
   - No

Level of Safety:

1. Do you always fasten your seatbelt?
   - ○ Yes ○ No
2. Are you having difficulty driving your car?
   - ○ Yes ○ No
3. Do you have a working smoke alarm in your home?
   - ○ Yes ○ No
4. Does your home have adequate lighting?
   - ○ Yes ○ No
5. Does your home have any loose rugs that might cause you to trip?
   - ○ Yes ○ No
6. Does your home have grab bars in the bathroom?
   - ○ Yes ○ No
7. Do you have difficulty with steps or stairs in your home?
   - ○ Yes ○ No ○ N/A
8. Does your home have handrails on the stairs?
   - ○ Yes ○ No ○ N/A
9. In the past 6 months, have you experienced leaking of urine?
   - ○ Yes ○ No

Social History:

1. Who do you live with?
   - ○ Spouse/ significant other ○ Family Member ○ Other
   - ○ Children ○ Friends
   - ○ Alone ○ Parent
2. How often do you have a drink containing alcohol?
   - ○ Never
   - ○ Monthly or less
   - ○ 2-4 times a month
   - ○ 2-3 times a week
   - ○ 4 or more times per week
3. How many standard drinks containing alcohol do you have on a typical day when you are drinking?
   - ○ 0-2
   - ○ 3-4
   - ○ 5-6
   - ○ 7-9
   - ○ 10 or more
4. In the last six (6) months, have you used one or more of the following substance(s)?
   - ○ Alcohol ○ Methamphetamine ○ None
   - ○ Marijuana ○ Intravenous
   - ○ Cocaine ○ Other
5. Do you currently smoke?
   - ○ Yes ○ No
6. Do you have any sexual health concerns?
   - ○ Yes ○ No

Diet/Physical Activity:

1. Do you eat five or more servings of fruit and vegetables a day?
   - o Yes
   - o No
2. Do you limit the amount of fried or high-fat foods you eat?
   - o Yes
   - o No
3. On average, how many days per week do you engage in moderate to strenuous exercise?
   ____
4. On average, how many minutes per session do you engage in exercise at this level?
   ____

Social Support:

1. Has your physical and emotional health limited your social activities with family, friends, or social groups?
   - o Yes
   - o No
2. Do you usually get the social and emotional support you need?
   - o Yes
   - o No
3. Does your stress affect your ability to sleep or have other negative effects on your health?
   - o Yes
   - o No
4. Over the past two weeks, how often have you been bothered by any of the following problems?
   Little interest/pleasure in doing things
   - o Not at all
   - o More than half the days
   - o Several Days
   - o Nearly every day
5. Over the past two weeks, how often have you been bothered by any of the following problems?
   Feeling down, depressed or hopeless?
   - o Not at all
   - o More than half the days
   - o Several Days
   - o Nearly every day

If you answered "not at all" on both questions 4 and 5, please skip to "General Health" on the next page. Otherwise complete numbers 6-12

6. Trouble falling asleep, staying asleep, or sleeping too much
   - o Not at all
   - o More than half the days
   - o Several Days
   - o Nearly every day
7. Feeling tired or having little energy
   - o Not at all
   - o More than half the days
   - o Several Days
   - o Nearly every day
8. Poor appetite or overeating
   - o Not at all
   - o More than half the days
   - o Several Days
   - o Nearly every day
9. Feeling bad about yourself - or that you're a failure or have let yourself or your family down
   - o Not at all
   - o More than half the days
   - o Several Days
   - o Nearly every day
10. Trouble concentrating on things, such as reading the newspaper or watching television
    - o Not at all
    - o More than half the days
    - o Several Days
    - o Nearly every day

11. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual
    - Not at all
    - Several Days
    - More than half the days
    - Nearly every day

12. Thoughts that you would be better off dead or of hurting yourself in some way
    - Not at all
    - Several Days
    - More than half the days
    - Nearly every day

General Health:

1. Do you have issues regarding your teeth or dentures?
    - Yes
    - No

2. In general, how would you rate your physical health?
    - Excellent
    - Very Good
    - Good
    - Fair
    - Poor

3. How confident are you that you can control and manage most of your health problems?
    - Very confident
    - Somewhat confident
    - Not confident

Please list all providers you see regularly and their specialty

______________________________ ______________________________

______________________________ ______________________________