Health Risk Assessment Today's date: _____ / _____ / _______

Your Name: ____ Date of Birth: _____ / _____ / _______

Age _____Under 65 _____ 65-69 _____ 70-79 _____ 80 or older
Gender _____ Male _____ Female

1) During the past four weeks, how much bodily pain have you generally had?
____No pain ____Very mild pain ____Mild pain ____Moderate pain ____Severe pain

2) During the past four weeks, was someone available to help you if you needed and wanted help? (For example: if you felt very nervous or lonely; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help taking care of yourself)
____Yes, as much as I wanted ____ Yes, quite a bit ____Yes, some ____Yes, a little ____No, not at all

3) During the past four weeks, what was the hardest physical activity you could do for at least two minutes?
____Very heavy ____Heavy ____Moderate ____Light ____Very light

4) Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?) ____Yes ____No

5) Can you go shopping for groceries or clothes without someone's help? ____Yes ____No

6) Can you prepare your own meals? ____Yes ____No

7) Can you do your housework without help? ____Yes ____No

8) Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house? ____Yes ____No

9) Can you handle your own money without help? ____Yes ____No

10) During the past four weeks, how would you rate your health in general?
____Excellent ____Very good ____Good ____Fair ____Poor

11) How have things been going for you during the past four weeks?
____Very well, could hardly be better ____Pretty well ____Good and bad parts about equal
____Pretty bad ____Very bad, could hardly be worse

12) Are you having difficulties driving your car?
____Yes, often ____Yes, sometimes ____No ____Not applicable, I do not use a car

13) Do you always fasten your seat belt when you are in a car? ____Yes, always ____Yes, sometimes ____No

14) How often during the past four weeks have you been bothered by any of the following problems?

Falling/dizzy when standing up	____Never	____Seldom	____Sometimes	____Often	____Always
Sexual problems	____Never	____Seldom	____Sometimes	____Often	____Always
Teeth or denture problems	____Never	____Seldom	____Sometimes	____Often	____Always
Problems using the telephone	____Never	____Seldom	____Sometimes	____Often	____Always

15) Are you a smoker? ____Yes, and I might quit ____Yes, but I'm not ready to quit ____No

16) During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?
____10 or more drinks per week ____6-9 drinks per week ____2-5 drinks per week
____One drink or less per week ____No alcohol at all

17) Do you exercise for about 20 minutes three or more days a week?
____Yes, most of the time ____Yes, some of the time ____No, I usually do not exercise this much

18) Have you been given any information to help you with the following:
Hazards in your house that might hurt you? ____Yes ____No
Keeping track of your medication? ____Yes ____No

19) How often do you have trouble taking medicines the way you have been told to take them?
____I do not have to take medicine ____I always take them as prescribed
____Sometimes I take them as prescribed ____I seldom take them as prescribed

20) How confident are you that you can control and manage most of your health problems?
____Very confident ____Somewhat confident ____Not very confident
____I do not have any health problems

21) Do you have a Living Will? ____Yes ____No ____Not Sure

PATIENT HEALTH QUESTIONNAIRE (PHQ-2/9)

Today's Date: ______________

Patient Name: _______________________________________ **Date of Birth:** ______________

Part of routine screening for your health includes reviewing mood and emotional concerns.
During the past two weeks, have you often been bothered by any of the following problems?

Little interest or pleasure in doing things? _____Yes _____No
Feeling down, depressed, irritable or hopeless? _____Yes _____No

If you answered "Yes" to either question above, please answer all questions below:

Over the last 2 weeks, how often have you been bothered by any of the following problems?	(0) **Not at all**	(1) **Several days**	(2) **More than half the days**	(3) **Nearly every day**
Little interest or pleasure in doing things				
Feeling down, depressed, irritable, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite, weight loss, or overeating				
Feeling bad about yourself — feeling that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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				
Thoughts that you would be better off dead, or of hurting yourself in some way				

If you are experiencing any of the problems above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
_____Not difficult at all _____Somewhat difficult _____Very difficult _____Extremely difficult

For Office Use Only **Total Score** ________

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FALLS SCREENING QUESTIONNAIRE

Today's Date: ______________

Patient Name: _______________________________________ Date of Birth: ______________

Please answer the following questions:

1. Have you fallen in the past year? _____Yes _____No

   If YES:

   a. How many times have you fallen? ___________________

   b. Were you injured? _____Yes _____No

2. Do you feel unsteady while standing or walking? _____Yes _____No

FOR OFFICE USE ONLY:

If patient answers YES to either Falls question above, perform TUG test.

Results of TUG test (in seconds): ______________

Did patient use assitive device? _____Yes _____No

If yes, what did they use? ____

Observe the patient's postural stability, gait, stride length, and sway.

Circle all that apply:

Slow tentative pace Loss of balance Short strides

Little or no arm swing Steadying self on nearby objects Shuffling

Notes:

Your Medical Providers

Primary Care Physician	Dry Ridge Family Medicine - Nicole Ogg, MD
Eye Doctor	____________________
Dentist	____________________
Chiropractor	____________________

Specialists

Cardiologist	____________________
Dermatologist	____________________
Endocrinologist	____________________
Gastroenterologist	____________________
Gynecologist	____________________
Infectious disease specialist	____________________
Internist	____________________
Neurologist	____________________
Orthopedist	____________________
Pain Management	____________________
Podiatrist	____________________
Rheumatologist	____________________
Urologist	____________________

Other Medical Providers

____________________	____________________
____________________	____________________
____________________	____________________

Verbal Communication Release Form

Our patients often want us to verbally communicate with family or friends who are assisting them in their treatment or payment for treatment. Please list below any **family or friends** with whom you authorize us to discuss your treatment/care or billing information, either in person or by phone.
This authorization will remain in effect for a period of one year from the date signed unless you revoke it.

Patient Name: ____ **Date of Birth:** _________________

____Communicate with me only

____Communicate with me and/or the following people:

Name (printed): ___________________________________ Relationship to Patient ____________
Treatment/Care Information: ____Yes ____No
Billing Information: ____Yes ____No

Name (printed): ___________________________________ Relationship to Patient ____________
Treatment/Care Information: ____Yes ____No
Billing Information: ____Yes ____No

Name (printed): ___________________________________ Relationship to Patient ____________
Treatment/Care Information: ____Yes ____No
Billing Information: ____Yes ____No

Name (printed): ___________________________________ Relationship to Patient ____________
Treatment/Care Information: ____Yes ____No
Billing Information: ____Yes ____No

Emergency Contact
Someone we may contact in the event of an emergency and we need to reach someone on your behalf.
Please provide an emergency contact even if you checked 'Communicate with me only' above.

Emergency Contact Name (printed): ____
Relationship to Patient: _________________________________
Phone (two numbers if available): Home: _______________ Cell: _______________
Work: _______________ Other: _______________

______________________________________ ______________________________________
Patient's Signature Today's Date

______________________________________ ______________________________________
If applicable, Authorized Representative Date
Relationship to Patient ______________________________