Patient Name: _____ D.O.B: _____ Date: _____

Advanced Directive:

Durable Power of Attorney	Yes, **Please provide a copy to the office.**	No
Declaration (Living Will)	Yes, **Please provide a copy to the office.**	No

Other Physicians:

Name:	Specialty:

Pharmacy

Name	Phone #:

Durable Medical Equipment:

Name:	Phone #:

Personal Safety

Do you live alone?	Yes	No
Do you have vision or hearing problems?	Yes	No
Do you have family in the area to assist you?	Yes	No

Immunizations

Have you had a flu shot?	Yes	No
Are immunizations up to date?	Yes	No
Immunizations due:		

Mobility/Fall Risk Assessment

Please mark "Yes" or "No" for each statement below.	Yes (1)	No (0)
I have fallen in the last 6 months.		
I use or have been advised to use a cane or walker to get around.		
Sometimes I feel unsteady when I am walking.		
I steady myself by holding onto furniture when I walk.		
I am worried about falling.		
I need to push with my hands to stand up from a chair.		
I am often dizzy when I first stand up.		
I have trouble stepping up onto a curb.		
I have lost some feeling or have pain in my feet.		
I take medicine that sometimes make me feel light-headed or more tired than usual.		
4 indicates potential fall risk.		
	Total	

Patient Name: _____ D.O.B: _____ Date: _____

PHQ2

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please mark one for each statement below.	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure in doing things?				
Feeling down, depressed, or hopeless?				

PHQ9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly everyday
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed, or hopeless.	0	1	2	3
Trouble falling asleep or sleeping too much.	0	1	2	3
Feeling tired or having little energy.	0	1	2	3
Poor appetite or overeating.	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down.	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
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.	0	1	2	3
Thoughts that you would be better off dead, or thoughts of hurting yourself.	0	1	2	3
Add columns		+	+	
TOTAL:				

If you checked off any problems, 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 _____

Patient Name: _____ D.O.B: _____ Date: _____

ADLs/IADLs

ADLs/ IADLs	Requires No Assistance	Some Assistance Needed	Complete Assistance Needed	Not Applicable
Bathing / Dressing / Grooming				
Oral Care / Toileting				
Transferring / Walking / Climbing Stairs				
Eating / Cooking				
Shopping / Driving				
Managing Medications				
Uses the Phone				
Housework / Laundry				
Managing Finances				
Totals				