PATIENT NAME: _____ **DOB:** _____

Self Assessment of Health:

Please *circle* one response for each question:

1) How do you rate your overall health in the past 4 weeks?

Excellent **Good** **Fair** **Poor**

2) Can you manage your overall health problems? **Yes** **No**

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

Yes **No**

4) Do you often get the emotional support you need?

Always **Usually** **Sometimes** **Rarely** **Never**

Mental Health Screening:

Over the last 2 weeks, how often have you experienced the following?	**Not at All**	**Several Days**	**More Than Half the Days**	**Nearly Every Day**
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Totals				

Pain Assessment:

In the past 2 weeks, how often have you experienced **body pain**?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Function and Mobility:

Do you have difficulty with the following activities?

Handling your medications?	I can do this by myself	I need some help to do it	I cannot do this; another person needs to do it for me
Handling your finances?	I can do this by myself	I need some help to do it	I cannot do this; another person needs to do it for me

When was your last fall? _____

In the last year, how many times have you fallen? _____

PATIENT SIGNATURE: _____ **DATE:** _____