Today's Date_____**Patient Name**_____**DOB** _____

WELLNESS QUESTIONAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems (circle your number)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
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 very difficult ☐		Somewhat difficult ☐	
	Very difficult ☐		Extremely difficult ☐	

1. In general how would you describe your overall health? (check one)
   - ☐ poor
   - ☐ fair
   - ☐ good
   - ☐ excellent
2. Do you have pain? How often does pain affect your normal activities? (check one)
   - ☐ never
   - ☐ rare
   - ☐ sometimes
   - ☐ often
   - ☐ always
   a. Rate your pain right now today on a scale from 0-10 (10 worst) _____
   b. Where is your pain?_____
   c. How are you treating it?_____
3. Do you have fatigue? How often does it affect your normal activities? (check one)
   - ☐ never
   - ☐ rare
   - ☐ sometimes
   - ☐ often
   - ☐ always
4. How often is stress a problem for you? (check one)
   - ☐ never
   - ☐ rare
   - ☐ sometimes
   - ☐ often
   - ☐ always
   - ☐
5. How do you handle the stress in your life? (check one)
   - ☐ I usually cope effectively

- ☐ At times difficult to cope
- ☐ Often difficult to cope

6. Do you have a support system of people who help you when you need it? (check all that apply)
   - ☐ Spouse
   - ☐ Children
   - ☐ Relatives
   - ☐ Friends
   - ☐ Community
7. How often do you get the social support/emotional support you need? (check one)
   - ☐ never
   - ☐ rare
   - ☐ sometimes
   - ☐ often
   - ☐ always

Have you fallen in the last year? -How many times?	Y	N
Do you worry about falling when walking or standing?	Y	N
Do you use a cane, walker or power chair? (**Circle one**)	Y	N
Are you able to drive safely?	Y	N
Do you consume caffeine? - How many cups in a day?	Y	N
Are you currently employed? - Fulltime or part time?	Y	N
Do you limit certain foods in your diet? (i.e. low fat, low carb, low salt, vegetarian etc.)? - If yes, what kind?	Y	N
Do you exercise? - How often?	Y	N
How many hours of sleep do you get a night?		Hours
Do you take naps during the day? - How often?	Y	N
Do you brush your teeth daily?	Y	N
Do you floss your teeth daily?	Y	N
When was your last dental visit?		
Do you use dentures or a dental appliance?	Y	N
Do you have urinary incontinence?	Y	N
Do you wear glasses or contacts?	Y	N
Do you use an assistive listening device? (hearing aid)	Y	N
Are you currently single, married, widowed, or divorced?		
Do you have any children?	Y	N
What kind of home do you live in? (i.e. single family home, mobile home, apartment, assisted living, etc.)		
Does your home have stairs?	Y	N
Do you have handrails for the stairs?	Y	N
Do you currently live with anyone? (spouse, friends, children, roommate, siblings, etc.)		
Do you have pets?	Y	N
Do you regularly wear a seatbelt?	Y	N
Is there a working smoke detector in your home?	Y	N

Today's Date_____**Patient Name**_____**DOB** _____

Do you have handrails in your bathroom?	Y	N
Is there a non-slip surface in your bathtub/shower?	Y	N
Do you have any unanchored rugs in your home?	Y	N
Are you sexually active?	Y	N
Do you have any history of substance abuse? If yes, what substance?	Y	N
Do you feel safe at home?	Y	N
Are you being physically or emotionally harmed?	Y	N
Do you need help with daily activities? - If yes, what activities?	Y	N
Do you have a living will? - If not, please ask for more information	Y	N

1. List all surgeries _____

   _____

   _____

2. Personal history of cancer? (including skin cancer) Yes No
   a. What kind of cancer?_____
3. Family History (stroke, cancer, diabetes, heart disease, etc.) Please include age at time of death

   Father: _____

   Mother: _____

   Siblings: _____

   _____
4. When was your last eye exam? What doctor?_____
5. When was your last DEXA/bone density scan and where?_____
6. When was your last mammogram and where?_____
7. When was your last colonoscopy and where? _____
8. When was your last stool occult card done? _____
9. If you are diabetic, when was your last foot exam? _____
10. If you have asthma, when was your last spirometry test? _____
11. List any other doctors seen at least within the last year _____

    _____

    _____
12. Have you received the following vaccines? When and Where?
    a. Flu shot _____
    b. Pneumonia _____
    c. Shingles _____