COMMUNITY CARE PHYSICIANS
Division of Family Care
Our Family Caring for Your Family

MEDICARE WELLNESS QUESTIONNAIRE

NAME: _____

DOB: _____/_____/_____ **DATE:** _____/_____/_____

Medical concerns to address today, if any: **(Please note your insurance may require an additional copay)**				
1. How would you rate your overall health?	☐ Good	☐ Fair	☐ Poor	
2. Tobacco use?	☐ Non-User ☐ Former User	☐ Second-hand exposure	☐ Current User ___ Packs/day	☐ I want info on quitting
3. Alcohol use?	☐ Non-User ☐ Former User	☐ Current User, type: ☐ Daily ☐ Socially ☐ Rarely ☐ Other: _____ ☐ I want info on quitting		
4. Recreational Drug Use?	☐ Non-User ☐ Former User	☐ Current User, please describe use (optional) _____ ☐ I want info on quitting		
5. How would you describe your diet?	☐ Balanced	☐ Unhealthy	☐Restricted: _____	☐Other: _____
6. How frequently do you exercise?	☐ No exercise	☐ 1-2 times/week Type:_____	☐ 3-5+ times/week Type:_____	
7. Hearing impairment?	☐ Normal	☐ Slight ☐ L ☐R ☐Both	☐ Significant ☐ L ☐R ☐Both	Hearing Aid? ☐ YES ☐NO
8. Do you have difficulty with the following tasks: **(Circle all that apply)** **9.** For any items selected, do you need assistance? ☐ **YES** ☐**NO**	Bathing Dressing Toileting Continence Feeding Personal Hygiene	Managing Finances Transportation Shopping Preparing Meals Managing Rx Meds Housework	Home Phone Use Affording Rx Meds Affording Groceries Affording Housing Paying Utility Bills Personal Safety	
10. Any falls in the last year?	☐ No falls	☐ Fall with injury How many? _____	☐ Fall without injury How many? _____	
11. Do any of the following fall risks apply to you? **(Circle all that apply)**	Multiple Pharmacies Sedative Use Urinary Incontinence Visual Impairment Mobility Impairment Alcohol Use	Cognitive Impairment Antihypertensive Use Antidepressant Use Loose Rugs Poor Lighting Unfamiliar Home	Uneven Floors No Grab Bars in Bath Household Clutter No Handrails on Stairs	
12. Do you have any Advanced Directives?	☐ None	☐ Living Will ☐Durable POA	☐ Healthcare Proxy	Want info? ☐ YES ☐NO

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DEPRESSION SCREENING (PHQ-2/PHQ-9)

NAME: _____

DOB: _____/_____/_____ **DATE:** _____/_____/_____

Over the last ***2 WEEKS***, how often have you been bothered by any of the following problems? **(Circle response)**	**Not at all** (0 days)	**Several days** (3-7 days)	**More than half of the days** (8-10 days)	**Nearly every day** (11-14 days)
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
If you selected "0" to #1-2, you are complete and may sign at the bottom of the page. If you selected anything other than "0", please complete the questions below then sign.				
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 or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading or watching TV.	0	1	2	3
8. Moving or speaking so slowly or quickly that other people noticed.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	**+**	**+**	
	TOTAL			

In the past year, have you had serious thoughts of suicide? ☐ **YES** ☐**NO** Have you EVER attempted? ☐ **YES** ☐**NO**	**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 Signature: _____ **Provider to Initial:** _____

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ANXIETY SCREENING (GAD-2/GAD-7)

NAME: _____

DOB: _____/_____/_____ **DATE:** _____/_____/_____

Over the last ***2 WEEKS***, how often have you been bothered by any of the following problems? **(Circle response)**	**Not at all** **(0 days)**	**Several days** (1-7 days)	**More than half of the days** (8-10 days)	**Nearly every day** (11-14 days)
1. Feeling nervous, anxious, or on edge	**0**	**1**	**2**	**3**
2. Not being able to stop or control worrying	**0**	**1**	**2**	**3**
If you selected "0" to #1-2, you are complete and may sign at the bottom of the page. If you selected anything other than "0", please complete the questions below then sign.				
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	add columns	**+**	**+**	
	TOTAL			

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**

Patent Signature: _____ **Provider to Initial:** _____