Patient Health Questionnaire (PHQ-9)

Patient Name:_____ Date of Birth: _____

Date of Visit_____

Over the past 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 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 or your family 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 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
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For Office Coding 0 + _____ + _____ + _____

= Total Score: _____

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 ☐

Fall prevention Assessment

	Yes	No
Have you had a fall within the past 12 months?		
• If yes, did you suffer an injury?		
Are you experiencing any difficulties with walking or balance?		

MEDICARE WELLNESS VISIT PATIENT HEALTH RISK ASSESSMENT QUESTIONNAIRE

Date:_____

Name:_____ DOB:_____

Please list your current healthcare providers: (Therapists, Specialists, etc.)

Optometrist:
Dentist:
Have you had any recent immunizations? (Do not include shots given here)

Have you had any preventative tests done recently? (ie. Mammograms, Colonoscopy, Lab tests)

Do you have a healthcare proxy?

How would you rate your general health?

Excellent_____ Very Good_____ Good _____ Fair_____ Poor_____

Do you have to strain or struggle to hear or understand conversations? Yes____ No____
Do you have issues with bladder control or urine leakage? Yes____ No____
Do you feel safe in your home? Yes____ No____

Do you complete your personal activities of daily living? (ie. dressing, bathing, shopping & house keeping) Yes____ No____

If not, do you require assistance?

Please review your health history form and complete the additional questionnaires

Signature _____

CLOCK DRAWING TASK

INSTRUCTIONS:

In the space below, please draw the face of a clock and put the numbers in the correct positions.

Now, draw in the hands at ten minutes after eleven.

Name_____

DOB_____ Date_____