PATIENT: _____ **WELLNESS QUESTIONNAIRE** (MC) (CIRCLE or CHECK) **DATE:** _____

Occupation	Retired	Disabled	Occupation: _____		
Race:	White	Asian	Hispanic	Black	Other:
Marital Status	Single	Married	Divorced	Widowed	

Hospitalization or Emergency Dept visit since last office visit?	None	Date	Hospital	Doctor	Reason
		_____	_____	_____	_____

Family History: *(Check all that apply)*	Father	Mother	Children	Siblings	Grandparents
High blood pressure	___	___	___	___	___
Heart disease	___	___	___	___	___
Stroke	___	___	___	___	___
Diabetes	___	___	___	___	___
High Cholesterol	___	___	___	___	___
Dementia	___	___	___	___	___
Depression	___	___	___	___	___
Write in Any Type of Cancer	_____	_____	_____	_____	_____

Pain level *(circle): 0 1 2 3 4 5 6 7 8 9 10 I go to a Pain Clinic I take chronic pain meds* Plan:

PHQ SCREEN *Mld 5-9 Mod 10-14 Mod-Sev 15-19 Sev >20-27*	(+) (-)	**Not at all** (0)	**Several days** (1)	**More than 1/2 days** (2)	**Nearly every day** (x3)
Over the past 2 weeks I have little interest or pleasure in doing things	*(Check one for each row)*	_____	_____	_____	_____
Over the past 2 weeks I have been feeling down, depressed or hopeless		_____	_____	_____	_____
Trouble sleeping	**Total**	_____	_____	_____	_____
Feeling tired, having little energy		_____	_____	_____	_____
Poor appetite or overeating		_____	_____	_____	_____
Feeling bad about yourself—or that you have let others down		_____	_____	_____	_____
Trouble concentrating		_____	_____	_____	_____
Have others noticed you moving or speaking slowly or being restless		_____	_____	_____	_____
Thoughts of hurting yourself or that you would be better off dead		_____	_____	_____	_____
How difficult have these problems made it for you?		*Not at all*	*Somewhat*	*Very*	*Extremely*

How often do you exercise?	*>3 per week*	*2-3 per wk*	*1-2 per wk*	*Never*

Compared with last year, how is your:	***Physical Health***			***Mental Health***			***Memory***		
(circle)	*Better*	*Same*	*Worse*	*Better*	*Same*	*Worse*	*Better*	*Same*	*Worse*

Do you leak urine?	*Yes*	*No*

Medical equipment in your home *(circle)*	*Cane*	*Walker*	*Wheelchair*	*Hospital bed*	*CPAP*	*Nebulizer*	*Oxygen*

Can you get to places out of walking distance, travel, or drive without help?	*Yes*	*No*

Difficulty driving? *No* *I do not drive* *Sometimes*	**Do you fasten your seat belt?** *Often*	*Sometimes*	*No*

I need help with ***(circle)*****:** *Phone*	*Transportation*	*Meals*	*Shopping*	*Housework*	*Medication*	*Handling my money*

Reviewed—John B. Crider, M.D.

PATIENT: _____ **WELLNESS QUESTIONNAIRE** (MC) (CIRCLE or CHECK) **DATE:** _____

Do you take regular narcotic pain medication? *Yes No*						
If YES, what other non-opioid pain treatments have you benefitted from? ***(circle below)***						
Anti-inflammatory medications	*Epidural Injections*	*Physical Therapy*	*Chiropractor*	*Surgery*		
Number of alcohol drinks you drink in an *average* day?	*0* *# per day: ___*	*I drank >4 drinks per day past 1 year* *I drank >15 drinks per wk past 3 months*			*No* *No*	*Yes* *Yes*
Is your alcohol use a concern for you or others?					*No*	*Yes*
How do you live?	*Alone*	*Spouse*	*Family*	*Institution*	*Other*	
How do you move around?	*I do not need assistance walking*	*I feel unsteady walking*	*I am unsteady & need assist*	*I walk with cane/walker*	*I use a wheelchair*	
Do you have difficulty with: Bathing / Grooming? *Yes No*	**Eating / Meal Prep?** *Yes No*	**Eating?** *Yes No*				
Over the past 2 weeks were there any days you did not take your medication as prescribed?					*No*	*Yes*
How often do you miss medication	*Never*	*Few per year*	*Few per month*	*Few a week*	*Frequently*	
What keeps you from taking your medications ***(cycle all that apply)*****?**	*Forgetfulness* *Side effects* *Cost*	*Do not understand directions*	*Do not understand why taking*	*Do not think medication is helping*	*Do not think medication is necessary*	
Describe your relationship with your spouse, partner, or caregiver	*No tension*			*Some tension*	*A lot of tension*	
You & your partner or caregiver work out arguments with …	*No difficulty*			*Some difficulty*	*Great difficulty*	
Physical activity versus last year	*More*	*Same*			*Less*	
Where do you live?	*Private home*	*Assist Living*	*Other:*			
Does your physical and emotional health limited your activities?	*Not at all*	*Slightly*	*Moderately*	*Quite a bit*	*Extremely*	
Hardest physical activity you could do for 2 minutes?	*Very heavy*	*Heavy*	*Moderate*	*Light*	*Very light*	
During the past 4 weeks, was someone available to help you if you needed help? *(felt nervous, lonely, blue; got sick, had to stay in bed; needed someone to talk to; needed help with daily chores, etc.)*	*Yes, as much as I wanted*	*Yes, quite a bit*	*Yes, some*	*Yes, a little*	*No, not at all*	
In the past year have you fallen or been injured from a fall?	*No*		*1 fall in past year*	*2 falls in past year*	*Injury from fall in past year*	
(*Circle all that apply*) *Dizzy when standing?*	*Feet feel numb or heavy*	*Lose balance when turning or bending*	*Trouble getting out of chairs*	*Trouble walking*	*Difficulty starting & stopping walking*	
List social or financial concerns:						
List your other Doctors & Specialists:						

Reviewed—John B. Crider, M.D.