

Citrus Park Medical Care
New Patient Form

Name _____ Date of Birth _____

Today's Date _____ Age _____ Sex _____

What name would you like to be called _____

Marital status single married divorced widowed

Occupation _____

Do you have allergies to medication, x-ray dyes or other substances yes no

If yes, please list medication and reaction _____

Please list name of medication, dosage and reason for taking medication

Have you ever had surgery yes no

If yes, please list any surgeries

Immunizations

Date of Tetanus vaccine _____

Date of TB screening _____

Date of Hepatitis B series _____

Date of last Flu vaccine _____

Date of last pneumonia vaccine _____

Health maintenance

Date of colonoscopy _____

Date of last bone density _____

Date of last pap smear _____

Date of last mammogram _____

Date of last eye exam _____

Do wear seat belts? Yes No

Do you drink alcohol? Yes No

Do you smoke cigarettes? Yes No

Do you use any illicit drugs? Yes No

Do you drink caffeine? Yes No

Which of the following conditions are currently being treated or have been treated for in the past?

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Sinus disease |
| <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Back pain | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Erectile dysfunction | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Headaches | <input type="checkbox"/> Other |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Schizophrenia | |

Family History- Please list family member (mother, father, maternal/paternal grandparent)

Were you adopted? Yes No

Heart disease _____
High cholesterol _____
High blood pressure _____
Diabetes _____
Heart Attack _____
Stroke _____
Liver disease _____
Asthma _____
Anemia _____
Breast cancer _____
Lung cancer _____
Ovarian cancer _____
Other cancer _____
Thyroid disease _____
Drug/Alcohol addiction _____
Depression/anxiety _____
Suicide _____
Seizure/epilepsy _____
HIV/AIDS _____
Other: _____

Please list reason for today's visit _____

Previous PCP

Name _____

Address _____

Phone _____

Fax _____

Authorization to Release Confidential Information

I, _____ (patient name) ___/___/___ (date of birth), authorize

_____ (doctor name/address or phone number) to disclose my health information to: Citrus Park Medical Care 6328 Gunn Hwy, Suite B Tampa, Fl. 33625
813-964-8526 Fax 813-964-8536 or Shital.Mehta@cit.ssdirect.aprima.com

Patient must read and initial both sections A and B, then sign and date. Thank you.

A. I CONSENT TO THE RELEASE OF THE HEALTH INFORMATION INITIALED BELOW:

___ All information

___ Only the information checked below:

<input type="checkbox"/> Clinical notes	<input type="checkbox"/> Lab and/or Radiology Reports	<input type="checkbox"/> Treatment Plan
<input type="checkbox"/> Case Management Records	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Psychiatric Evaluation

Other (Specify): _____

B. THE HEALTH INFORMATION DISCLOSE SHOULD INCLUDE THE FOLLOWING SPECIFIC HEALTH INFORMATION INITIALED BELOW : (___ initial if waiving this section if not pertinent or do not authorize to disclose)

By placing initials next to a category of highly confidential information listed below, I specifically authorize the use and / or disclosure of the confidential information.

___ Alcohol and/or drug abuse information ___ Hiv/Aids information ___ Sexual Assault

___ Mental Health Records of information ___ Abuse of an adult or child ___ Developmental Disability

If applicable, please add any limits (like by provider, date, service type) _____

This information is needed for the following purpose(s) Checked Below:

___ Treatment ___ Coordination of Care ___ Case Management ___ PCP Communication

___ Other (please specify) _____

I understand that I may refuse or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation of care or quality of treatment. Unless revoked, this consent will expire on the following date, event or condition: _____. Otherwise, this consent will remain valid for twelve (12) months from date this consent was signed.

Authorization to Release Confidential Information

SIGNATURE OF PATIENT/PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE**

DATE

PRINT NAME

** Relationship to Patient _____

**If you are signing as the patient's legally authorized representative, please attach the appropriate legal document(s) granting you the authority to do so (i.e., Health Care Power of Attorney, Court Order, etc.).

Agreement for use of controlled substances

I understand that the main goal of treatment with chronic controlled substances is to improve my ability to function and/or work and/or reduce pain.

In consideration of that goal, and the fact that I am being given potent medication to help me to reach that goal, I agree to help myself by following better health habits, including exercise, weight control, safe sex, avoiding the use of tobacco, alcohol, and illegal drugs/substances.

Chronic controlled substance medication are intended to improve function and quality of life.

I must comply with the treatment plan as prescribed by my provider.

I understand that only through following a healthier lifestyle can I hope to have the most successful outcome to my treatment. Because my provider is prescribing such medication for me to help manage my diagnosis, I agree to the following conditions:

1. I am responsible for my controlled substance medications.

If the medication(s) are lost, misplaced, or stolen, or if I use it up sooner than prescribed, I understand that **it may not be replaced**. I will not increase or decrease my dosage without talking with my provider. _____

2. I will not request or accept controlled substance medication from any other provider or facility without notifying Citrus Park Medical Care, except in emergency or urgent healthcare situations.

I acknowledge that receiving duplicate medications may endanger my health. The only exception is an emergency or urgent healthcare situation.

I will not allow anyone else to use my medication and will keep them secure. _____

3. Refills of chronic controlled substance medications should be:

A. Will be made during regular clinic hours. Refills will not be made at night, on holidays or weekends.

B. Any exceptions such as "I ran out early" or "I lost my prescription" or "I spilled or misplaced my medicine" must be addressed by your provider.

I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining.

C. If I need assistance with a chronic controlled substance medication prescription, I will call to discuss this with my provider. _____

4. My provider may require me to see a specialist at any time while I am receiving controlled substance medications.

If I am unable to meet the requirements of this agreement, there may be medical and safety risks of continuing my controlled substance medication. I understand that my medications may not be continued or refilled. _____

5. I agree to comply with random laboratory testing documenting the proper use of my medications and confirming compliance. I understand the importance of avoiding alcohol

or other substances of abuse when taking a controlled substance medication. A positive test for any substance besides my prescribed medications will be grounds for action and/or discontinuation of my medications. _____

6. I understand that controlled substances can cause marked drowsiness. I will not drive a motor vehicle or operate dangerous equipment while I am sleepy. I understand that I will need to talk with my provider about my ability to drive or operate dangerous equipment. It is my responsibility to comply with the laws of the State of Florida while taking the medications prescribed. _____

7. I understand that if I violate any of the above conditions, my controlled substance prescriptions may be tapered and not refilled, or ended immediately and alternative treatments for pain offered. If the violation involves obtaining controlled substances from any other individual, as described above, or the use of street (illegal) drugs, I may be reported to my provider, medical facilities, and other agencies as appropriate. _____

8. I understand that the long-term advantages and disadvantages of chronic opiate usage have yet to be scientifically determined. I understand that my treatment may change throughout my time as a patient. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances, and that my provider will advise me of medical advances and will discuss treatment changes with me as appropriate. _____

I have been fully informed by Citrus Park Medical Care and staff regarding the probability of addiction to a controlled substance, which I understand is low.

I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the desired effect. In addition, I know that by increasing the medication, a physical dependence of medication use will be created. This will occur if I am on the medication for several weeks. When I stop the medication, I must do so slowly under a plan developed with my provider, or I may have withdrawal symptoms.

I have read this agreement. By signing this agreement I hereby grant my provider the right to contact any other professional involved in my care concerning my use of opioid medications.

I fully understand the consequences of violating this agreement.

Name of patient

DOB

Patient signature

Date

Provider signature

Date

Citrus Park Medical Care Financial Policy

We consider payment of services to be the responsibility of the patient-physician relationship. Therefore, we would like to share our payment policy expectations with you to ensure understanding and compliance.

We participate with various insurance companies and managed care plans, which we will file on your behalf directly to the insurance carrier for payment, less any co-payments, coinsurance, deductibles and non-covered benefits.

Please make sure that on your commercial managed plans that you choose us as your primary care providers. If we are not the doctors of choice we will not be able to provide you with service in the office. Also, make sure that your insurance is active before making an appointment or you will be charged the full cost of the office visit.

Payment is expected at the time of service. We accept cash, check, Visa, MasterCard, and Discover card.

ON ALL RETURNED CHECKS FOR NON-SUFFICIENT FUNDS there is a \$25.00 fee charged back to the patient. We will be unable to accept any personal checks until account balance and associated service fees are paid in full. If this becomes a repeated offense, we will only be able to accept cash.

By signing below, I have read and understand the payment terms and my obligations within the Financial Policy.

Thank you for understanding our financial policy. Please let us know if you have any additional questions or concerns.

Signature of patient or person responsible for account

Date

Citrus Park Medical Care

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review this carefully.

Purpose of privacy notice

This notice of privacy practices describes how we may use and disclose your protected health information to carry out treatments, initiate payment or conduct healthcare operations or for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information (PHI) is information about you, including demographic information that may identify you and that related to your past, present, or future physical and/or mental health or condition and related healthcare services.

This notice describes the privacy policies of our practice and that of: any healthcare professional authorized to enter information into your medical record including all employees of the practice.

Our pledge regarding medical information:

We understand that medical information about you and health is personal and we are committed to protected it. A record of the care and services you receive at this practice is created and maintained at this location. This notice applies to all of those records of your care.

We are required by law to make sure that medical information that identifies you is kept private. We will give you notice of our legal duties and privacy practices regarding your medical information. We will follow the terms of this notice currently in effect. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling our office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

How we may use and disclose medical information about you:

The following categories describe ways that we use and disclose medical information. Examples of each category are included and not every use or disclosure in each category is listed; however, all of the ways we are permitted to use and disclose information falls into one of these categories.

For treatment: We may use medical information about you to provide, coordinate or manage medical treatment and services. We may disclose medical information about you to other physicians or healthcare providers who are or will be involved in taking care of you.

For payment: We may use and disclose medical information about you so that the

treatment and services you receive at our practice may be billed and payment may be collected from you, your insurance company, or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval to determine whether your plan will cover treatment, or for undertaking utilization review activities.

For healthcare operations: We may use or disclose your PHI in order to support business activities for our practice. These activities include but are not limited to, quality assessment activities, employee review activities and conducting or arranging for other activities.

We may share your PHI with third-party "business associates" that perform various activities (billing) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Sale or closure of practice: In the event that Citrus Park Medical Care is sold or acquired by another facility or physician group, your PHI will be disclosed to that group or entity.

Required by law, legal proceeding or law enforcement: We may use or disclose your PHI to the extent that the use or disclosure is required by law.

Public Health: We may disclose your PHI for public health activities and purpose to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury, or disability.

Communicable diseases: We may disclose your PHI as authorized by law to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health oversight: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the healthcare system, government benefit programs, or other governmental regulatory programs and civil rights law.

Your Rights

The following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and obtain a copy of your PHI about you that is contained in the designated records set for as long as we maintained the PHI

You have the right to request a restriction of your PHI which means you may ask us not to disclose any part of your PHI for the purpose of treatment, payment or healthcare operations you may also request that any part of your PHI not be disclosed to family

members or friends who may be involved in your care or for notification purposes. Other uses or disclosures of your PHI will be made only with your written authorization unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

We may use and disclose your PHI if the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines using professional judgment that you intend to consent to use or disclose under the circumstances.

You may have the right to have the practice amend your PHI. This means you may request an amendment of your information. In certain cases we may deny your request for amendment. You have the right to file a statement of disagreement with us and we may prepare a rebuttal of your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as disclosed in this Notice of Privacy Practices. It excludes disclosures we may have made to you, to family members or friends involved in your care or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after January 1, 2006. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office administrator. We will not retaliate against you for filing a complaint.

Please place your initials _____

Date _____

Authorization of Examination, Treatment, and Use/Disclosure of Protected Healthcare Information (PHI) for Treatment, Payment, and Healthcare Operations Acknowledgement

I hereby authorize the physicians at Citrus Park Medical Care and staff to examine and/or render treatment. I understand that this may also include diagnostic imaging, use of scopes to examine internal organs, and lab tests (i.e. blood-work, pathology, etc.). I understand that I will receive explanation of ordered procedures/associated risks, and explanation of proper preparation for such procedures. I understand that I reserve the right to inquire about alternative courses of treatment and I will be given opportunity to have all of my questions answered.

I agree and understand that I have been provided with a Notice of Privacy Practices that provides a description on how my PHI will be used and disclosed. I understand that Citrus Park Medical Care reserves the right to change any policies at any time. I understand that I have the right to object to the use of my PHI for directory purposes. I understand that I reserve the right to request restrictions as to how my PHI is disclosed to carry out treatment, payment, and healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

With whom may we share your PHI (full name/relationship to patient):

By signing below, I acknowledge that I have received the Notice of Privacy Practices for the uses/disclosures of my protected health information, the General Administrative and Financial agreement, and Authorization of Examination. I understand these documents in full and I have been given the opportunity to have all of my questions answered.

Print name

Patient Signature

Date

Living Wills - Advance Health Care Directives

A living will allows you to decide whether you desire life support under certain circumstances. It is a declaration that such procedures be withheld or withdrawn, and that you be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide you with comfortable care.

Living Will Legal Definition

Adults in all States have the right to make decisions about their health care. They are given the right to accept or reject medical or surgical treatment after being informed of their options. Health care decisions can be made by you, or an agent you appoint to make decisions if you are not capable of making the decision at that time. Forms used for health care matters vary from State to State, but generally are one or more of the following: Living Will, Health Care Directive, Durable Power of Attorney for Health Care, health care proxy and others. A Living Will may also be called a Declaration, Living Will Declaration, Health Care Declaration, Health Care Directive, Advance Health Care Directive, Health Care Proxy and others. Sometime you will see the form named Statutory Living Will or Statutory Health Care Directive.

Living Wills

Although the term Living Will may indicate that it is a Will, in reality, it is more similar to a Power of Attorney than a Will. Therefore, don't be confused by the title of the document. The purpose of a living will is to allow you to make decisions about life support and directs others to implement your desires in that regard.

Living Wills are needed because advances in medicine allow doctors to prolong and sustain life although the person will not recover from a persistent vegetative state. Some people would not desire to remain in that state while others would. Extending life when death is imminent to some people is only extending the suffering and prolonging the dying process.

The Living Will allows you to make the decision of whether life-prolonging medical or surgical procedures are to be continued, or withheld or withdrawn, as well as when artificial feeding and fluids are to be used or withheld. It allows you to express your wishes prior to being incapacitated. Your physicians or health care providers are directed by the Living Will to follow your instructions. You may revoke the Living Will prior to becoming incapacitated.

The Living Will generally becomes operative when it is provided to your physician or health care provider AND you are incapable of making health care decisions for yourself, such as where you are permanently unconscious or terminally ill and unable to communicate.

Durable power of attorney for Health Care

A durable power of attorney for health care is used to appoint an agent to make health care decisions for you and usually includes the power of the agent to make decisions regarding terminal conditions and whether to prolong life. However, if you have a Living Will, the directions of the Living Will control over the durable power of attorney, because you have already made the decision of what is to be done under certain circumstances. Many people use a Durable Power of Attorney for Health Care and a Living Will because they do not want to place the agent in the position of making decisions regarding choice in dying. The agent still has authority to make other health care decisions for you when you cannot make the decision yourself in situations where you need medical attention but are not terminally ill or in a permanent coma.

Citrus Park Medical Care
6328 Gunn Hwy, Suite B
Tampa, FL 33625
813-964-8526
813-964-8536 FX

Please let us know your wishes:

Check ALL that apply:

_____ I have a living will. (If yes, please provide a copy).

_____ I have a document that I signed that allows another person to make healthcare decisions for me. (If yes, please provide a copy).

_____ If I ever become too sick to make my own healthcare decisions, I give the following person permission to make them for me:

Name: _____

Phone number: _____

If I become so ill that I cannot tell my doctor what I want, and two doctors agree that they cannot make me better, please: (Check ALL that apply)

_____ Keep me clean and free from pain.

_____ Do Not use tubes for: _____ breathing _____ feeding _____ IV fluids.

_____ Let my appointed person decide.

_____ If my heart stops, do _____ do not _____ try to restart it.

_____ Do EVERYTHING possible.

_____ I do not wish to complete an advanced directive at this time

Additional instructions:

Printed name: _____ Date: _____

Signature: _____ Date: _____

1st Witness: _____ Date: _____

Relationship: _____

2nd Witness: _____ Date: _____

Relationship: _____

Please note, the person designated as surrogate shall not act as a witness and at least one person who acts as a witness shall neither be the principal's spouse or blood relative.

Your surrogate may consult with your health care providers and give informed consent to perform medical procedures that the surrogate feels are in your best interest and make health care decisions for you that the surrogate believes that you would have made under the circumstances if you were capable of making such decisions. Your surrogate has access to your clinical records and has the authority to release information and records to appropriate persons to ensure the continuity of your health care. If there is no indication of what you would have chosen, the surrogate may consider what is in your best interest in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn.

To: Our Medicare Patients:

Subject: Medicare Annual Wellness and Other Preventive Visits

Beginning January 1, 2011, Medicare covers an “Annual Wellness Visit” in addition to the one-time “Welcome to Medicare” exam. The “Welcome to Medicare” exam occurs only once during your first twelve months as a Medicare patient. You may receive your Annual Wellness Visit after you have been with Medicare for more than one year, or it has been at least one year since your “Welcome to Medicare” exam.

Initial Preventive Physical Exam (IPPE)	“Welcome to Medicare” is only for <i>new</i> Medicare patients. This must be done in the 1 st year as a Medicare patient.
Annual Wellness Visit, Initial	At least 1 yr after the “Welcome to Medicare” exam.
Annual Wellness Visit, Subsequent	Once a year (more than 1 yr + 1 day after the last Wellness Visit).

The Annual Wellness Visit is not the same thing as what many people often refer to as their yearly physical exam. Medicare is very specific about what the “Annual Wellness Visit” includes and excludes.

At the Annual Wellness Visit, your doctor will talk to you about your medical history, review your risk factors, and make a personalized prevention plan to keep you healthy. The visit does *not* include a hands-on exam or any testing that your doctor may recommend, nor does it include any discussion about any new or current medical problems, conditions, or medications. You may schedule another visit to address those issues *or* your doctor may charge the usual Medicare fees for such services that are beyond the scope of the Annual Wellness Visit.

If you would like to schedule an annual physical, including any lab work or other diagnostic testing, medication management, vaccinations, and other services, please understand that these services will be charged and covered according to Medicare’s usual coverage guidelines. However, you may still develop a care plan based on the Annual Wellness Visit criteria.

We appreciate the trust you put in us to take care of your health care needs and hope that you will take advantage of this new benefit to work with your physician in creating your personalized prevention plan.

See the attached list to bring with you to your appointment.

What you should bring to your Annual Wellness Visit:

The names of all your doctors:

Name	Specialty

A list of all your medications

Name of medicine	Dose	How medication is taken (1 daily, PRN)

Have you had any tests done in the past year? Yes No
(such as blood tests, colonoscopy, mammograms, x-rays, CT scan, MRI, etc.)

Test Name	Date

Have you had any recent immunizations? Yes No

Do you have a living will or advance directive?
(If you have one, *please bring a copy of it with you.*) Yes No

Patient Name: _____ DOB: _____ Date: _____

1. Can you get places out of walking distance without help?
*For example, can you travel alone by bus, taxi, or drive your own car?

- Yes
- No

2. Can you shop for groceries or clothes without help?

- Yes
- No

3. Can you prepare your own meals?

- Yes
- No

4. Can you do your own housework without help?

- Yes
- No

5. Can you handle your own money without help?

- Yes
- No

6. Do you need help eating, bathing, dressing, or getting around your home?

- Yes
- No

7. Are you having difficulties driving your car?

- No
- Sometimes
- Yes, often
- Not applicable, I do not use a car

8. Have you been given any information to help you keep track of your medications?

- Yes
- No

9. How often do you have trouble taking medicines the way you have been told to take them?

- I do not have to take medicine
- I always take them as prescribed
- Sometimes I take them as prescribed
- I seldom take them as prescribed

10. During the past 4 weeks, was someone available to help you if you needed and wanted help?

*For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.

- Yes, as much as I wanted
- Yes, quite a bit
- Yes, some
- Yes, a little
- No, not at all

11. How often in the past 4 weeks, have you had trouble eating well?

- Never
- Seldom
- Sometimes
- Often
- Always

12. How often in the past 4 weeks, have you been bothered by your teeth or dentures?

- Never
- Seldom
- Sometimes
- Often
- Always

13. How often in the past 4 weeks, have you had problems using the telephone?

- Never
- Seldom
- Sometimes
- Often

Patient Name: _____ DOB: _____ Date: _____

- Always
14. Have you been given any information to help you identify hazards in your house that might hurt you?
 Yes
 No
15. Do you always fasten your seatbelt when you are in a car?
 Yes, Usually
 Yes, Sometimes
 No
16. Have you had sex in the past 12 months (vaginal, oral or anal)?
 Yes
 No
17. Have you ever had a sexually transmitted disease?
 Yes
 No
18. During the past 4 weeks, how much bodily pain have you generally had?
 No pain
 Very mild pain
 Mild pain
 Moderate pain
 Severe pain
19. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
 Very heavy
 Heavy
 Moderate
 Light
 Very light

20. During the past 4 weeks, how would you rate your general health?
 Excellent
 Very good
 Good
 Fair
 Poor
21. How have things been going for you in the past 4 weeks?
 Very well – could hardly be better
 Pretty good
 Good and bad are about equal
 Pretty bad
 Very bad – could hardly be worse
22. How confident are you that you can control and manage most of your health problems?
 Very confident
 Somewhat confident
 Not very confident
 I do not have any health problems
23. Over the past 2 weeks, have you experienced having little interest or pleasure in doing things?
 Yes
 No
24. Over the past 2 weeks, have you been feeling down, depressed or hopeless?
 Yes
 No
25. Are you a smoker?
 No
 Yes, and I might quit
 Yes, but I am not ready to quit

Patient Name: _____ DOB: _____ Date: _____

26. Did you have a drink containing alcohol in the past year?

Yes

No

27. Have you fallen two (2) or more times in the past year?

Yes

No

28. Were you injured in any falls in the past year?

Yes

No