Siena Proactive Internal Medicine – Smithtown

Patient Name: ____ Patient's Date of Birth: ___________________

(Please Print)

General Care Management – Patient Level - **PLEASE CIRCLE ANSWERS**

1. **Assessment completed with:** children - family - paid caregiver - parents – Patient – spouse/significant other
2. **Enrolled in care management program:** Yes – No
3. **Primary Care Giver:** friend – family member – parent/legal guardian – self – significant other – caregiver – other
4. **Living Arrangement:** alone – caregiver – family members – foster care – foster parent – friends – parent/legal guardian – significant other – multiple residents
5. **Employment Status:** employed but on leave for health reasons – employed (or self-employed) – not employed – retired
6. **Support System:** none – case manager – community organization – counselor – family – friends – home care staff – neighbors – paid help - parents – religious organization – shelter – spouse/partner – twelve step group
7. **Family conflict:** Yes – No
8. **Type of residence:** apartment – assisted living – group home – homeless – mental health residence – nursing home – one-story home – private residence – two-story home
9. **Home care services:** Yes – No
10. **Equipment used at home:** none – cane – walker – bedside commode – tub seat – oxygen/respiratory treatment – wheelchair – hospital bed
11. **Communication device:** Yes – No
12. **Financial problems:** Yes – No
13. **Transportation issues:** Yes – No
14. **Transportation means:** accessible car – caretaker – family – friend – public transportation – public transportation taxi – regular car – self – ambulette
15. **Communication and other barriers:** no communication barriers – reading barrier – writing barrier – cultural barriers – auditory barriers – cognitive barriers
16. **Bed or wheelchair confined:** Yes – No
17. **Diet:** celiac – diabetic diet – low cholesterol – low saturated fat – other diet – regular – low sodium
18. **Other Health Risks:** a change in medication – none – obesity – sedentary lifestyle – smoking/tobacco exposure – lack of dental/oral care
19. **Exercise:** yes – not currently exercising – unable to exercise
    a. **Minutes per day:** ________________________
    b. **Times per week:** ________________________
    c. **Type of exercise:** ________________________
20. **Inadequate activity/exercise:** Yes – No
21. **Medication adherence:** Yes – No
22. **Experiencing side effects from current medications:** Yes – No
23. **History of falls in last 6 months:** Yes – No
24. **Difficulty keeping appointments:** Yes – No
25. **Family aware of the patient's advance care planning wishes:** Yes – No
26. **Religious or spiritual beliefs that impact treatment:** Yes – No
27. **Chronic pain:** Yes – No
    a. **Location of chronic pain:** _____________________________
    b. **Chronic pain timing:** intermittent – constant
    c. **Chronic pain severity:** 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 - 9 – 10
    d. **Limitation of routine activities due to chronic pain:** none – mild – moderate – severe

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(Please Print)

Social Determinants of Care Screening - **PLEASE CIRCLE ANSWERS**

1. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? **Yes – No**

2. In the last 12 months, has the electric, gas, oil, or water company threatened to shut off your services in your home? **Yes – No**

3. Are you worried that in the next 2months, you may not have stable housing? **Yes – No**

4. Do problems getting child care make it difficult for you to work or study?
   Yes – No – N/A no children

5. In the last 12 months, have you needed to see a doctor, but could not because of cost? **Yes – No**

6. In the last 12 months, have you ever had to go without health care because you didn't have a way to get there? **Yes – No**

7. Do you ever need help reading hospital materials? **Yes – No**

8. I often feel that I lack companionship: **Yes – No**

9. Are any of your needs urgent? (For example: I don't have food tonight, I don't have a place to sleep tonight) **Yes – No**

10. If you checked YES to any questions above, would you like to receive assistance with any of these needs? **Yes - No**

Name: ____ **DOB:**____________________

Adult Alcohol and Drug Screening

Please circle YES or NO to the following questions:

1. Do you drink alcohol?

Yes

No

2. Have you ever experimented with drugs?

Yes

No

If you answered 'YES' to either question, please answer the following questions:

1. In the last three months, have you felt you should cut down or stop drinking or using drugs?

Yes

No

2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?

Yes

No

3. In the last three months, have you felt guilty or bad about how much you drink or use drugs?

Yes

No

4. In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?

Yes

No

Siena Proactive Internal Medicine – Smithtown

Patient Name: ____Today's Date ____________________

(Please Print)

Patient's Date of Birth: _____________________________________

Please circle your answers:

1. Do you have a Health Care Proxy or a Legal Guardian? **YES or NO**
   a. If YES, please print their name below:

____ ___________________________________

(Health Care Proxy/Legal Guardian Name) (Contact Phone Number #)

2. Do you have a Primary Care Giver (someone who provides day-to-day care, and receives instructions about your care)? **YES or NO**
   a. If YES, please print their name and contact number below:

____ ___________________________________

(Primary Care Giver Name) (Contact Phone Number #)

3. Do you have an Advanced Directive (example: Living Will, Power of Attorney, etc.)? **YES or NO**
   a. If YES, please bring a copy with you to put into your chart at your next visit.

***Health Care Proxy forms are available – Please ask one of our staff members if you are interested.

Patient Name: ________________________

Fall Screening

Please answer the following questions (check Yes or No):	Yes	No
Have you had two or more falls in the past year?		
Have you had any fall that resulted in an injury in the past year?		
Do you have difficulty with walking or balance?		
If you answered YES to the previous question, do you use a cane, walker or wheelchair?		
Do you have uncorrected vision problems such as glaucoma or cataracts?		

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	Yes	No
Is the patient identified for "Risk of Falls?"		
Was the patient given educational information on Falls?		
Is the patient wheelchair bound?		
Does the patient present with an acute fall?		

Patient Name: ______________________

Depression Screening

Over the last two weeks, how often have you been bothered by any of the following? Circle One.	Not at all	Several Days	More than half the day(s)	Nearly every day
Little interest or pleasure in doing things.	0	1	2	3
Feeling down, depressed or hopeless.	0	1	2	3
Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling badly about yourself, or that you are a failure or have let yourself or your family down.	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed, or the opposite – being fidgety or restless so that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3

If you circled any problems above, how difficult have these problems made it for you to do your work, take care of things, and get along with other people? Circle one.

Not Difficult
Somewhat Difficult
Very Difficult
Extremely Difficult

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PHQ Total Score ___________