FAMILY CARE
SOUTHWEST, P.C.

Please complete this checklist before your appointment, and bring it in with you.

During the past ***4 weeks*** How much bodily pain have you generally had?

___No Pain. ___Very Mild Pain. ___Mild Pain. ___Moderate Pain. ___Severe Pain.

Where is the pain located?_____

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.

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

Can you shop for groceries or clothes without help?
____Yes. ___No.

Can you prepare your own meals?
___Yes. ___No.

Can you do your own housework without help?
___Yes. ___No.

Can you handle your own money without help?
___Yes. ___No.

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

Do you feel you have a good support system to help you if you need it?
___Yes. ___No.

During the past ***4 weeks*** how would you rate your health in general?
___Excellent. ___Very good. ___Good. ___Fair. ___Poor.

During the past ***4 weeks*** how have things been going for you?
___Very well. ___Pretty good. ___Equally good and bad. ___Pretty bad. ___Very bad.

Are you having difficulties driving your car?
___Yes, often. ___Sometimes. ___No. ___I do not use a car.

Do you fasten your seatbelt when you are in a car?
___Yes, always. ___Sometimes. ___No.

Have you fallen 2 or more times in the past year?
___Yes. ___No.

Are you afraid of falling?
___Yes. ___No.
Do you exercise for about 20 minutes 3 or more times a week?
___Yes, most of the time. ___Some of the time. ___Not usually. ___No.

Name_____ Date of Birth_____

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How often during the past ***4 weeks*** have you been bothered by the following problems

	Never	Less than 1/2 of the days	More than 1/2 of the days	Daily
Feeling dizzy when standing up				
Sexual problems				
Difficulty eating				
Tooth or denture difficulties				
Difficulty using a telephone				
Difficulty Hearing				
Feeling more tired/ fatigued				
Forgetting to take medication				
Difficulty with bowel/bladder				

Are you worried about your memory?
___Yes. ___I am not but my family/friends are. ___There are no concerns.

How confident are you in managing most of your health problems?
___Very Confident. __Somewhat Confident. ___Not Confident. ___I have no health problems.

Do you have a Medical Power of Attorney?
___Yes, and I believe you have it on file. ___Yes, and I brought it today. ___No.

Do you have a Living Will?
___Yes, and I believe you have it on file. ___Yes, and I brought it today. ___No.

Anything specific you want to address today?**Additional questions can be brought up but may require an additional office visit.

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Name_____ Date of Birth_____