Staying Healthy Assessment

Senior

Patient's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date
Person Completing Form *(if patient needs help)*	☐ Family Member ☐ Friend ☐ Other *(Specify)*		Need help with form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables every day?	Yes	No	Skip	
3	Do you limit the amount of fried food or fast food that you eat?	Yes	No	Skip	
4	Are you easily able to get enough healthy food?	Yes	No	Skip	
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?	No	Yes	Skip	
6	Do you often eat too much or too little food?	No	Yes	Skip	
7	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	Physical Activity
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	
20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	

21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	In the past year, have you had 4 or more alcohol drinks in one day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Mental Health	☐	☐	☐	☐
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐
☐ Sexual Issues	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Name:_____ **Date:** _____

Welcome to Omni Family Health!

Our healthcare providers are asking every patient the age of 12 and over to answer a few questions about his/her health habits. These questions are asked in order to provide you with the best and most complete care possible by allowing your doctor to get a better understanding of your health habits. This form is confidential and will not be released to anyone outside of Omni Family Health without your signed permission. If you have any questions, please feel free to ask the front office staff for clarification.

Patient Health Questionnaire- 2 (PHQ-2)

Over the last two 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

For office coding: __**0**__ + _____ +_____ + _____

= Total Score_____

If the total score is more than zero (0), please proceed to answer the next questionnaire PHQ-9.

Patient Health Questionnaire- 9 (PHQ-9)
To be completed every 6 months

Over the last two 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 asleep, 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, feeling that you are a failure, or feeling that you have let yourself or family down	0	1	2	3
7. Trouble concentration on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thinking that you would be better off dead, or that you want to hurt yourself in someway	0	1	2	3
Add Columns				
10. 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

Welcome to Omni Family Health!

Name: _____ Date: _____

GAD - 7				
Over the last 2 weeks, how often have you been bothered by the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly early every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Total Score = _____ (Add the score for each column)				
Scoring Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.				

Name: _____ **Date: _____**

Welcome to Omni Family Health!

Our healthcare providers are asking every patient over the age of 18 to answer a few questions about his/her health habits. These questions are asked in order to provide you with the best and most complete care possible by allowing your doctor to get a better understanding of your health habits. This form is confidential and will not be released to anyone outside of Omni Family Health without your signed permission. If you have any questions, please feel free to ask the front office staff for clarification.

DAST-10
To be completed once a year

The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth. The following questions concern information about your potential involvement with drugs **excluding** alcohol and tobacco during the past 12 months.

When the word "drug abuse" is used, they mean the use of prescribed or over-the-counter medications used in excess of the directions and any non-medical use of any drugs.

The various classes of drugs may include but are not limited to: cannabis (marijuana, hash), solvents (gas, paints, etc.), tranquilizers (valium), barbiturates, cocaine, stimulants (speed), hallucinogens (LSD), or narcotics (heroin).

These questions refer to the past 12 months only.	Yes	No
1. Have you used drugs other than those required for medical use?		
2. Do you abuse more than one drug at a time?		
3. Are you always able to stop using drugs when you want to?		
4. Have you had “blackouts” or “flashbacks” as a result of drug use?		
5. Do you ever feel bad or guilty about your drug use?		
6. Does your spouse (or parent) ever complain about your involvement with drugs?		
7. Have you neglected your family because of your use of drugs?		
8. Have you engaged in illegal activities in order to obtain drugs?		
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
10. Have you had medical problems as a result of your drug use (memory loss, hepatitis, convulsions, bleeding)?		
***DAST Score**		

Name: _____ **Date: _____**

CAGE Questioner
To be completed once a year

	Yes	No
Have you ever felt you should **C**ut down on your drinking?		
Have people **A**nnoyed you by criticizing your drinking?		
Have you ever felt **G**uilty about your drinking?		
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?		