Capital Internal Medicine Associates, P.C.

*A New Beginning OB/GYN *CIMA Breast Center
*CIMA Main Office * Haslett Primary Care *Mount Hope Clinic
*Williamston Primary Care

Medicare Health Risk Assessment

Patient Name: _____ Date of Birth: _____

Date of visit: _____

Name of person assisting with completing this form if applicable: _____

Advanced Directives:

Do you have a living will? □ Yes □ No

Do you have a Healthcare Power of Attorney? □ Yes □ No □ I would like information

If yes, who is your Power of Attorney? _____ **Living**

Arrangement:

□ Alone □ Spouse/Partner □ Family Member □Assisted Living/Retirement Community □ Other_____

Marital Status:

□ Married □ Widowed □ Divorced □ Separated □ Never Married **Functional**

and Safety:

Are you deaf or have serious difficulty hearing? □ Yes □ No

Are you legally blind or have difficulty seeing? □ Yes □ No Do you wear glasses? □ Yes □ No

Last eye exam: _____

How often in the last 4 weeks have you been bothered by teeth or denture problems?
□ Never □ Seldom □ Sometimes □ Often □ Always

Last dental exam: _____

Do you fasten your seatbelt when you are in the car? □Yes □No

On average, how many days a week do you engage in moderate to strenuous exercise? Number of days _____ Length of exercise each day_____

Please mark any of the following you have serious difficulty managing on your own:

□Walking □ Climbing Stairs □ Dressing □ Bathing □ Using the bathroom □ Driving

□Shopping □ Managing Medication □Using telephone □ Housework □Cooking/Prepping Meals

During the last 4 weeks, was someone available to help you if you needed and wanted? □
No assistance needed □ Yes, as much as I wanted □ Yes, Some □ No, not at all

Do you depend on others for personal care? □ Yes □ No

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Cognitive:
Do you have difficulty concentrating, remembering, or making decisions? □ Yes □ No

Concerns about your memory if any: _____

General:
During the past four weeks, how would you rate your health in general?

□ Excellent □ Very Good □ Good □ Fair □ Poor

During the past 4 weeks, please rate any pain you have experienced on a scale of 1-10?
□ No Pain (0) □ Very Mild (1-2) □ Mild (3-4) □ Moderate (5-6) □ Moderately Severe (7-8) □ Severe (9-10)

Each night, how many hours of sleep do you usually get? _____

Do you snore or have you been told you snore? □ Yes □ No

Sexual Health:
Are you currently sexually active: □ Yes □ No

How often during the past 4 weeks have you been bothered by sexual problems? □
Never □ Seldom □ Sometimes □ Often □ Always

Financial:
How hard is it for you to pay for the basics like food, housing/mortgage, medical care, and heating/cooling?
□ Very Hard □ Hard □ Somewhat Hard □ Not very hard □ Not hard at all

Transportation:
In the past 12 months, has lack of transportation keep you from medical appointments, from getting medications, getting to work, or getting things needed for daily living? □ Yes □ No

Social:
In a typical week, how many times do you interact with family, friends, social groups, church groups or neighbors?
□Never □ One a week □ Twice a week □ Three times a week □ More than three times a week

Circle of Care:
Please list all the providers that you are currently seeing or have seen in the past 12 months (please include your eye care providers and any specialists)

_____

_____

_____

The Group Health Plan within the Capital Internal Medicine Associates, PC Employee Benefits Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish	ATENCIÓN:	si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-517-374-7600.
2Arabic	ب رقم ات ص------ل .بالمج ----ان ل --ك تتواف----------ر اللغوي--------ة المس---اعدة خدمات ف----إن ،اللغ-----ة انك--ر تتح---------ث كن ----ت إذا 7600-1-517-374 ملحوظة:	

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PATIENT HEALTH OUESTIONNAIRE-9 (PHQ-9)

Nearly every day	**Over the last 2 weeks, how often have you been bothered by any of the following problems?** *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days
	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 or 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 — or that you are a failure or have let yourself or your family down	0	1	2	3
	7. Trouble concentrating 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 the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
	9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

NAME: _____ **DOB:** _____

Signature: _____ **DATE:** _____

Patient Account Number: _____

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Fall Risk Assessment

Patient Name: _____ D.O.B. _____ Date: _____

Patient Account Number: _____

PLEASE CIRCLE "YES" OR "NO" FOR EACH STATEMENT BELOW

I have fallen in the past year.	Yes (2)	No (0)
If yes, how many times have you fallen? _____		
If yes, were you injured? _____		
I use or have been advised to use a cane or walker to get around safely.	Yes (2)	No (0)
Sometimes I feel unsteady when I am walking.	Yes (1)	No (0)
I steady myself by holding onto furniture when walking at home.	Yes (1)	No (0)
I am worried about falling.	Yes (1)	No (0)
I need to push with my hands to stand up from a chair.	Yes (1)	No (0)
I have some trouble stepping up onto a curb.	Yes (1)	No (0)
I often have to rush to the toilet.	Yes (1)	No (0)
I have lost some feeling in my feet.	Yes (1)	No (0)
I take medicine that makes me feel more light headed or tired than usual.	Yes (1)	No (0)
I take medicine to help me sleep or improve my mood.	Yes (1)	No (0)
I often feel sad or depressed.	Yes (1)	No (0)

Total Points:_____

****Add up the total number of points. If you scored 4 or more points, you may be at risk for falling****