Sparta Community Hospital
Quality Healthcare Clinics

Dear: _____

Thank you for scheduling a wellness visit. Medicare and Medicare replacement insurance products pay for very specific wellness care, as the goal is to keep you healthy and be proactive in identifying any potential health issues. Typically, this is a FREE service to you, covered by Medicare and Medicare replacement plans.

At your wellness visit, a nurse will gather a complete health history and provide you with some specific other measures, prescribed by Medicare as important measures to identify opportunities to improve or maintain your health status. Please know, your wellness visit may not include a physical exam as this is not a required element by Medicare for this visit. This visit will include at a minimum;

- A screening to detect depression, risk of falling, and other problems.
- A limited physical exam to check your blood pressure, height, weight, vision, and other things depending on your age, gender, and level of activity.
- Recommendations for other wellness services and healthy lifestyle changes.

Before your appointment, our staff will ask you to fill out a form with a series of questions about your health. These forms were included with this letter. We ask that you complete these forms and bring them to your appointment. Please also be sure to bring all of your medications, in the bottles, that you are currently taking from all of your healthcare providers, as well as a list of those providers and their phone numbers.

If you have any specific health concerns, please be sure to let the nurse know at your wellness visit, so that a separate appointment can be scheduled to address those issues.

We want to make sure that we are part of the team that keeps you healthy, and offers you the best quality of life possible. Medicare and Medicare replacement insurance benefits are also part of that team, and we want you to get the most of the benefits that are offered to you.

It is our pleasure to be your healthcare provider of choice!

Sincerely,

Medicare Health Risk Assessment

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

Your name: _____

Today's date: _____

Your date of birth: _____

1. During the **past four weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

2. During the **past four weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

3. During the **past four weeks**, how much bodily pain have you generally had?

- ☐ No pain.
- ☐ Very mild pain.
- ☐ Mild pain.
- ☐ Moderate pain.
- ☐ Severe pain.

4. During the **past four 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.

5. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

- ☐ Very heavy.
- ☐ Heavy.
- ☐ Moderate.
- ☐ Light.
- ☐ Very light.

6. Can you get to places out of walking distance without help? (For example, can you travel alone on buses or taxis, or drive your own car?)

- ☐ Yes. ☐ No.

7. Can you go shopping for groceries or clothes without someone's help?

- ☐ Yes. ☐ No.

8. Can you prepare your own meals?

- ☐ Yes. ☐ No.

9. Can you do your housework without help?

- ☐ Yes. ☐ No.

10. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?

- ☐ Yes. ☐ No.

11. Can you handle your own money without help?

- ☐ Yes. ☐ No.

12. During the **past four weeks**, how would you rate your health in general?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

continued ➤

Provider reviewed - Initials: _____ date:_____

Your Name:_____

Today's date:_____

Your date of birth:_____

13. How have things been going for you during the **past four weeks**?

- ☐ Very well; could hardly be better.
- ☐ Pretty well.
- ☐ Good and bad parts about equal.
- ☐ Pretty bad.
- ☐ Very bad; could hardly be worse.

14. Are you having difficulties driving your car?

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

15. Do you always fasten your seat belt when you are in a car?

- ☐ Yes, usually.
- ☐ Yes, sometimes.
- ☐ No.

16. How often during the **past four weeks** have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing					
Sexual problems.					
Trouble eating well.					
Teeth or denture problems.					
Problems using the telephone.					
Tiredness or fatigue.					

17. Have you fallen two or more times in **the past year**?

- ☐ Yes. ☐ No.

18. Are you afraid of falling?

- ☐ Yes. ☐ No.

19. Are you a smoker?

- ☐ No.
- ☐ Yes, and I might quit.
- ☐ Yes, but I'm not ready to quit.

20. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

- ☐ 10 or more drinks per week.
- ☐ 6-9 drinks per week.
- ☐ 2-5 drinks per week.
- ☐ One drink or less per week.
- ☐ No alcohol at all.

21. Do you exercise for about 20 minutes three or more days a week?

- ☐ Yes, most of the time.
- ☐ Yes, some of the time.
- ☐ No, I usually do not exercise this much.

22. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

☐ Yes. ☐ No.

Keeping track of your medications?

☐ Yes. ☐ No.

23. 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.

24. 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.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed form to the receptionist.

Provider reviewed - Initials: _____ date:_____

STEADI Fall Risk Evaluation
Required annually for anyone age 65 years or older

Name:_____ DOB:_____ Date:_____

1. Have you fallen in the past year? (if no, skip to Number 4)	Yes	No
2. Number of falls in past year		
3. Number of falls resulting in an injury		
4. Do you feel unsteady when standing or walking?	Yes	No
5. Do you worry about falling?	Yes	No
6. Do you use or have you been advised to use a cane or walker?	Yes	No
7. Do you steady yourself by holding onto furniture?	Yes	No
8. Do you push with your hand(s) to stand up from a chair?	Yes	No
9. Do you have trouble stepping up onto a curb?	Yes	No
10. Do you use medications that cause lightheadedness or more tired than usual?	Yes	No
11. Do you use medication for sleep or to improve your mood?	Yes	No
12. Do you often feel sad or depressed?	Yes	No
13. Do you often have to rush to the toilet?	Yes	No
14. Have you lost some feeling in your feet?	Yes	No

For office use only:

Transfer answers from form to Documentation Template. Update, complete and SHRED form.

Sparta Community Hospital

PHQ-9 Healthcare Screening

Patient Name:_____ **Date of Birth:**_____

Date of Visit:_____

	Not at all	Several days	More than half the days	Nearly every day
Do you have a current diagnosis of bipolar disorder?	No		Yes (STOP)	
1.**Little Interest/Pleasure in Things** - In the last 2 weeks, how often have you had little interest or pleasure in doing things?	0	1	2	3
2.**Feeling Down, Depressed or Hopeless** - In the last 2 weeks, how often have you felt down, depressed or hopeless?	0	1	2	3
Score: _____ If <3, stop				
3.**Trouble Falling or Staying Asleep/Sleeping Too Much** - In the last 2 weeks how often have you had trouble falling or staying asleep or sleeping too much?	0	1	2	3
4.**Feeling Tired or Having Little Energy** - In the last 2 weeks, how often have you felt tired or had little energy?	0	1	2	3
5.**Poor Appetite or Overeating** - In the last 2 weeks, how often have you had a poor appetite or overeaten?	0	1	2	3
6.**Feeling Bad About Yourself** - In the last 2 weeks, how often have you felt 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** - In the last 2 weeks, how often have you had trouble concentrating on things like reading newspaper or watching television?	0	1	2	3
8.**Moving/Speaking Slowly, Being Fidgety/ Restless** - In the last 2 weeks, how often have you been moving or speaking so slowly that other people could have noticed?	0	1	2	3
9.**Thoughts That You Would Be Better Off Dead or Hurting Yourself** - In the last 2 weeks, how often have you had thoughts that you would be better off dead or hurting yourself in some way?	0	1	2	3
Total Score, all 9 questions: _____				

How Difficult Have Problems Made It - How difficult have 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

For Office Use Only:

Transfer answers from form to PHQ9 Documentation Template. Update & Complete Template. Shred form.

Healthy Brain Checklist ™

Name _____ **Date** _____

1. Do you require assistance remembering appointments, family occasions, holidays or taking medications?

☐ Yes ☐ No

2. Check each symptom with which you are having *increasing difficulty*, compared to your past ability:

Symptoms of Medical Conditions	Symptoms of Normal Aging
☐ Forgetting important details of things I have done in the past few weeks.	☐ Forgetting the name of someone I know well.
☐ Forgetting to do things I said I would do.	☐ Forgetting what I was going to say in a conversation.
☐ Forgetting recent events or conversations.	☐ Forgetting what I was going to do when going into another room.
☐ Retelling a story or joke to the same person because I forgot that I had already told them.	☐ Finding things I have just put down.
☐ Completing complex tasks at work or home (i.e. balancing checkbook, planning projects).	☐ Recalling a specifc word I want.
	☐ None of these apply

3. Check each feeling that applies: "During the last month I have..."

☐ Felt that I cannot stop feeling "down" or "blue", even with help from family or friends. Felt
☐ all pleasure and joy has gone from life.
☐ Felt hopeless about the future.
☐ Felt that everything was an effort.
☐ Felt low in energy or slowed down a lot.
☐ None of these apply

Please note any other memory or mood-related concerns to discuss with your doctor:

_____

_____

_____

_____

_____

_____

I have reviewed this form:_____ Date:_____