Name: _____

DOB: _____

PHQ-9 Questionnaire

Date: _____

Over the past **two weeks**, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
   - [__] Not at all
   - [__] Several days
   - [__] More than half the days
   - [__] Nearly every day

2. Feeling down, depressed, or hopeless
   - [__] Not at all
   - [__] Several days
   - [__] More than half the days
   - [__] Nearly every day

3. Trouble falling or staying asleep, or sleeping too much
   - [__] Not at all
   - [__] Several days
   - [__] More than half the days
   - [__] Nearly every day

4. Feeling tired or having little energy
   - [__] Not at all
   - [__] Several days
   - [__] More than half the days
   - [__] Nearly every day

5. Poor appetite or overeating
   - [__] Not at all
   - [__] Several days
   - [__] More than half the days
   - [__] Nearly every day

6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down
   - [__] Not at all
   - [__] Several days
   - [__] More than half the days
   - [__] Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television
   - [__] Not at all
   - [__] Several days
   - [__] More than half the days
   - [__] Nearly every day

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
   - [__] Not at all
   - [__] Several days
   - [__] More than half the days
   - [__] Nearly every day

9. Thoughts that you would be better off dead or of hurting yourself in some way
   - [__] Not at all
   - [__] Several days
   - [__] More than half the days
   - [__] Nearly every day

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

Name: _____
DOB: _____

MEDICARE WELLNESS HEALTH RISK ASSESSMENT
Date: _____

Answer these questions before seeing your doctor or nurse.
Your responses will help you receive the best health and health care possible.

1. Have you been hospitalized or had any major illnesses or changes in your health status in the past year?

_____

2. Do you have an Advanced Health Care Directive?
____Yes ____No

3. Do you live alone?
____ Yes ___ No
Who else lives in your home?_____

4. Are you a care provider for someone else?
____ Yes ___No
Who?_____

5. Have you fallen more than two times **in the past year**?*
___ Yes ___ No

6. Are you afraid of falling?*
___ Yes ___ No

7. Are you a smoker?
___ No
___ Yes, and I might quit
___ Yes, but I'm not ready to quit

8. 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

9. 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

10. 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

11. 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

12. 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

13. During the **past four weeks,** how much body pain have you generally had?
___ No pain
___ Very mild pain
___ Mild pain
___ Moderate pain
___ Severe pain

14. 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

15. 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

16. Can you go shopping for groceries or clothes without someone's help?**
___Yes ___ No

17. Can you prepare your own meals?**
___Yes ___ No

18. Can you do housework without help?**
___Yes ___ No

Name: _____

DOB: _____

19. Are you having difficulties driving your car?
___ Yes, often
___ Sometimes
___ No
___ Not applicable, I do not use a car

20. Do you always fasten your seat belt when you are in a car?
___ Yes, usually
___ Yes, sometimes
___ No

21. Do you have trouble thinking clearly or remembering?
___ Often
___ Sometimes
___ Never

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

Falling or dizzy standing up:	Often	Sometimes	Never
Trouble eating well:	Often	Sometimes	Never
Teeth or denture problems:	Often	Sometimes	Never
Problems using the telephone:	Often	Sometimes	Never
Tiredness or fatigue:	Often	Sometimes	Never

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

25. Have you noticed any hearing difficulties?
____ Yes ___No

26. Does your home have rugs in the hallways?
____ Yes ___No

27. Does your home have grab bars in the bathroom?
____ Yes ___No

28. Does your home have handrails down the stairs?
____ Yes ___No

29. Does your home have good lighting?
____ Yes ___No

30. Because of any health problems, do you need the help of another person with your personal needs such as eating, bathing, dressing, or getting around the house?**
___Yes ___ No

31. Can you handle your own money without help?**
___Yes ___ No

Thank you very much for completing this health assessment. Please give the completed form back to your nurse.

* if out of range, do TUG test.
** if out of range, do Mini-Cog.