ARETE PROVIDER NETWORK
Arete Family Medicine - Anchorage

Patient name: _____

Patient DoB: _____

Medicare Wellness Risk Assessment

Today's date: _____

Answer these questions before seeing your doctor or nurse. Your responses will help you receive the best 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 (living will)? ☐ Yes ☐ No

3) Do you live alone? ☐ Yes ☐ No
If No, who else lives in your home? _____
_____

4) Are you a care provider for someone else?
☐ Yes ☐ No If Yes, who? _____
_____

5) Have you fallen more than two times **in the past year**?* ☐ Yes ☐ No If Yes, what happened?_____
_____

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) Do you drink sugary beverages?
☐ Yes ☐ No
If Yes, # servings/day? _____

9) How many servings of vegetables and fruits do you eat per day? _____
_____

10) 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

11) 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

12) During the **past four weeks**, what was the hardest physical activity level you could do for at least two minutes?
☐ Very heavy
☐ Heavy
☐ Moderate
☐ Light
☐ Very light

Clinical use only
* *If out of range, do TUG test*
** *If out of range, do Mini-Cog*

Medicare Wellness Risk Assessment (cont.)

13) 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

14) 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

15) During the **past four weeks**, how much body pain have you generally had?

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

16) 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

17) 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

18) Can you go shopping for groceries or clothes without someone's help?**

☐ Yes ☐ No

19) Can you prepare your own meals?**

☐ Yes ☐ No

20) Can you do housework without help?**

☐ Yes ☐ No

21) Are you having difficulties driving your car?

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

Clinical use only

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Medicare Wellness Risk Assessment (cont.)

22) Do you always fasten your seat belt when you are in a car?
- ☐ Yes, always
- ☐ Sometimes
- ☐ No

23) Do you have trouble thinking clearly or remembering?
- ☐ Often
- ☐ Sometimes
- ☐ Never

24) 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

25) How often do you have trouble taking medicines the way you have been told to take them?
- ☐ I do not need to take medicine
- ☐ I always take them as prescribed
- ☐ Sometimes I take them as prescribed
- ☐ I seldom take them as prescribed

26) 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

27) Have you noticed any hearing difficulties?
☐ Yes ☐ No
Do you have hearing aids? ☐ Yes ☐ No

28) Does your home have throw rugs in the hallways?
☐ Yes ☐ No

29) Does your home have grab bars in the bathroom?
☐ Yes ☐ No

30) Does your home have handrails down the stairs?
☐ Yes ☐ No ☐ Not applicable

31) Does your home have good lighting?
☐ Yes ☐ No

32) 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

33) Can you handle your own money without help?**
☐ Yes ☐ No

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Patient name: _____

Medicare Wellness Risk Assessment (PHQ-9)

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

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