BW PRIMARY CARE
Bridge to Wellness

Patient Name:_____

Patient DOB: _____

Today's Date:_____

Annual Medicare Wellness Questionnaire

Please complete this checklist before seeing your provider. Your responses will help you receive the best healthcare possible.

1. What is your age?

____ 65-69 ____ 70-79 ____ 80 or Older

2. Are you Male or Female? ___ Male ___ Female

3. 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.

4. 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.

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

___ No pain.
___ Very Mild Pain.
___ Mild pain.
___ Moderate pain.
___ Severe pain.

6. 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.

7. 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.

8. 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

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

___ Yes ___ No

10. Can you prepare your own meals?

___ Yes ___ No

11. Can you do housework without help?

___ Yes ___ No

12. 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

13. Can you handle your own money without help?

___ Yes ___ No

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

___ Excellent.
___ Very good.
___ Good.
___ Fair.
___ Poor.

15. 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.

16. Are you having difficulties driving your car?

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

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

___ Yes, usually.
___ Yes, sometimes.
___ No.

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

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

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

___ Yes ___ No

20. Are you afraid of falling?

___ Yes ___ No

21. Are you a smoker?

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

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

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

23. Do you exercise for about 20 minutes three or more times per week?

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

24. 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 medication?

___ Yes ___ No

25. How often do you have trouble taking medications 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.

26. How confident are you that you can control and manage most of your health problems?

___ Very confident.
___ Someone confident.
___ Not very confident.
___ I do not have any health problems.

27. What is your race? (Check all that apply)

___ White
___ Black or African American
___ Asian.
___ Native Hawaiian or other Pacific Islander.
___ American Indian or Alaskan Native.
___ Hispanic or Latino origin or descent.
___ Other.

Thank you very much for completing your Medicare Wellness checkup. Please give the completed form to your provider or nurse.

Patient Name: _____Patient DOB: _____ Today's Date: _____

Over the past 2 (two) weeks, how often have you been bothered by any of the following problems? (circle which applies)

	Not at all	Several days	More than half of 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, or that you're 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 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
Add Columns (Healthcare professional: For interpretation of TOTAL, please refer to scoring card)				

Add Total Number of Points: _____

10. If you checked off any problems, how difficult have these problems made it 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

SBIRT Questions

Patient Name: _____ Patient DOB: _____ Today's Date: _____

1. **How often do you have a drink containing alcohol?**

   ☐ Never ☐ Monthly or less ☐ 2-3 times a month ☐ 2-3 times a week
   ☐ 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**

   ☐ 0 ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

3. **How often do you have six or more drinks on one occasion?**

   ☐Never ☐ Less than monthly ☐ Monthly ☐Weekly ☐ Daily or almost daily

4. **In the last 12 months, did you use Marijuana or another street drug?** ☐ Yes ☐ No

5. **In the last 12 months, did you use a prescription painkiller, stimulant, or sedative for nonmedical reasons?** ☐ Yes☐ No

CLOCK DRAW TEST

Patient Name: _____
DOB: _____
Date: _____

1.) Inside the circle, please draw the hours of a clock as they normally appear
2.) Place hands of the clock to represent the time: "ten minutes after eleven o'clock"