MaxHealth

Annual Wellness Questionnaire

Section 1: COA

1. Employment Status
   - ☐ Employed
   - ☐ Retired
   - ☐ Medically unable to work
   - ☐ Unemployed

2. In the last 4 weeks, how often did you struggle paying for food?
   - ☐ Never
   - ☐ Occasionally
   - ☐ Sometimes
   - ☐ Often
   - ☐ All the time

3. In the last 4 weeks, how often did you struggle paying for medication?
   - ☐ Never
   - ☐ Occasionally
   - ☐ Sometimes
   - ☐ Often
   - ☐ All the time

4. Do you struggle with finding or maintaining housing?
   - ☐ Yes
   - ☐ No

5. Do you exercise for about 20 minutes 3 or more times a week?
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ No, I don't usually exercise this much

6. During the past 4 weeks, how much bodily pain have you had?
   - ☐ No pain
   - ☐ Very mild pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe pain

7. Where is the location of your pain?
   - ☐ Head
   - ☐ Shoulder(s)

- ☐ Neck/Back
- ☐ Arm(s)
- ☐ Leg(s)
- ☐ Knee(s)
- ☐ Hip(s)
- ☐ Hand(s)/Finger(s)
- ☐ Other_____

8. On a scale of 0-10 (0 is no pain), how bad is your pain?
   - ☐ 0
   - ☐ 1
   - ☐ 2
   - ☐ 3
   - ☐ 4
   - ☐ 5
   - ☐ 6
   - ☐ 7
   - ☐ 8
   - ☐ 9
   - ☐ 10

9. Do you use an assistive device for walking?
   - ☐ None
   - ☐ Cane
   - ☐ Walker
   - ☐ Wheel Chair

10. How often do you use your assistive device?
    - ☐ I don't use a device
    - ☐ All the time
    - ☐ Quite often
    - ☐ Sometimes
    - ☐ Rarely
    - ☐ Never

11. Do you have a hearing impairment that requires special equipment?
    - ☐ Yes
    - ☐ No

12. Do you have difficulty seeing and recognizing an object at arm's length or difficulty reading?
    - ☐ Yes
    - ☐ No

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13. Do you have difficulty starting and maintaining a conversation?
    - ☐ Yes
    - ☐ No

14. In the past 4 weeks, how often did you have trouble thinking, remembering or making decisions?
    - ☐ Not at all
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Often
    - ☐ Most of the time

15. Do you struggle with
    - ☐ Transportation
    - ☐ Shopping
    - ☐ Grooming or bathing
    - ☐ Preparing meals
    - ☐ Housework
    - ☐ Eating without help
    - ☐ Getting around your home

16. In the past 4 weeks, have you had trouble with:
    - ☐ Sexual problems
    - ☐ Trouble eating well
    - ☐ Teeth or dentures
    - ☐ Using telephone
    - ☐ Tired or fatigue

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Section 2: HOS

17. Do you exercise for about 20 minutes 3 or more times a week?
    - ☐ Yes, most of the time
    - ☐ Yes, some of the time
    - ☐ No, I don't usually exercise this much

18. Have you fallen 2 or more times in the past 12 months?
    - ☐ Yes
    - ☐ No

19. Are you afraid of falling?
    - ☐ Yes
    - ☐ No

20. Do you have any bladder control or issue with urine leakage?
    - ☐ Yes

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Section 3: Wellness Questionnaire

21. During the past 4 weeks, how would you rate your health in general?
    - ☐ Excellent
    - ☐ Very good
    - ☐ Good
    - ☐ Fair
    - ☐ Poor
22. Do you use tobacco products?
    - ☐ No
    - ☐ Yes, but I might be willing to quit
    - ☐ Yes, and I am not ready to quit
23. Have you been to the emergency room 2 or more times in the last 12 months?
    - ☐ Yes
    - ☐ No

24. Have you been admitted to the hospital in the last 12 months?
    - ☐ Yes
    - ☐ No

25. How often do you have trouble taking medicine the way you have been told to them?
    - ☐ I don't take medicine
    - ☐ I always take them as prescribed
    - ☐ I sometimes take them as prescribed
    - ☐ I seldom take them as prescribed

26. Are you having difficulties driving your car?
    - ☐ Yes, often
    - ☐ Sometimes
    - ☐ No, never
    - ☐ I don't drive a car

27. Do you have any Advanced Directives?
    - ☐ Advanced Directives
    - ☐ Living Will
    - ☐ Actionable medical order/Do Not Resuscitate
    - ☐ Designated healthcare surrogate

28. Have you ever had a stroke?
    - ☐ No
    - ☐ Yes

      If Yes - Do you have any residual side effects?

- ☐ Face impairment
- ☐ Arm or limb weakness or numbness
- ☐ Visual difficulties
- ☐ Speech impairment or slurring

29. Do you have a joint replacement?
    - ☐ Knee
    - ☐ Hip
    - ☐ Other
    - ☐ None

    If Yes - Do you have any pain in the replaced joint?
    - ☐ Yes
    - ☐ No

30. Have you ever been diagnosed with COPD (Chronic Obstructive Pulmonary Disease)?
    - ☐ No
    - ☐ Yes

    If Yes – When was your last breathing test (Spirometry)?
    - ☐ Within the last year
    - ☐ Over a year ago
    - ☐ I don't know
    - ☐ I have never had this test

31. Are you on oxygen therapy?
    - ☐ Yes
    - ☐ No

32. Do you have an amputated limb?
    - ☐ None
    - ☐ Above the knee (right)
    - ☐ Above the knee (left)
    - ☐ Below the knee (right)
    - ☐ Below the knee (left)
    - ☐ Toe(s)
    - ☐ Foot/feet
    - ☐ Ankle

33. Have you been diagnosed with diabetes?
    - ☐ No
    - ☐ Yes

    If Yes – When was your last dilated eye exam?

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- ☐ Within the last year
- ☐ Over a year ago
- ☐ I don't know
- ☐ I have never had this exam

When were your feet last examined?

- ☐ Within the last year
- ☐ Over a year ago
- ☐ I don't know
- ☐ I have never had this exam

Are you on medication to control your cholesterol?

- ☐ Yes
- ☐ No

Do you have numbness or tingling in your lower limbs or feet?

- ☐ Yes
- ☐ No