Annual Wellness Questionnaire

Section 1: COA

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

2. Within the past 12 months, did you worry that your food would run out before you got money to buy more?
   - Yes
   - No

3. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?
   - Yes
   - No

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

5. Do you have housing?
   - Yes
   - No

6. Are you worried about losing your housing?
   - Yes
   - No

7. Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed?
   - Yes
   - No

8. Do you feel physically and emotionally safe where you currently live?
   - Yes
   - No

9. Within the past 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by someone?
    - Yes
    - No

10. Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?
    - Yes
    - No

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

12. 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____

13. 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

14. Do you use an assistive device for walking?
    - Yes
    - No

    a. If Yes – What type of device do you use?
        - Cane
        - Walker
        - Wheel Chair
        - Other

    b. If Yes - How often do you use your assistive device?
        - All the time
        - Quite often
        - Sometimes
        - Rarely
        - Never

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

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

17. Do you have difficulty starting and focusing on maintaining a conversation?
    - Yes
    - No

18. 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

19. Do you struggle with:
    - Transportation
    - Shopping
    - Grooming or bathing
    - Preparing meals
    - Housework

- Eating without help
- Getting around your home

20. Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need?
    - Yes
    - No

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

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

Section 2: HOS

23. 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

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

25. Are you afraid of falling?
    - Yes
    - No

26. Do you have any bladder control or issue with urine leakage?
    - Yes
    - No

Section 3: Wellness

27. During the past 4 weeks, how would you rate your health in general?
    - o Excellent
    - o Very good
    - o Good
    - o Fair
    - o Poor

28. Have you been to the emergency room 2 or more times in the last 12 months?
    - o Yes
    - o No

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

30. How often do you have trouble taking medicine the way you have been told to take your medicine?
    - o I don't take medicine
    - o I always take my medicine as prescribed
    - o I sometimes take my medicine as prescribed
    - o I seldom take my medicine as prescribed

31. Do you have any Advanced Directives?
    - o Living Will
    - o Actionable medical order/Do Not Resuscitate
    - o Designated healthcare surrogate or proxy

32. Have you ever had a stroke?
    - o Yes
    - o No

    a. If Yes - Do you have any residual side effects?
       - o Face impairment
       - o Arm or limb weakness or numbness
       - o Visual difficulties
       - o Speech impairment or slurring

33. Do you have a joint replacement?
    - Yes
    - No

    a. If yes - Which joint(s) have been replaced?
        - Knee
        - Hip
        - Other

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

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

    a. 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

35. Are you on oxygen therapy?
    - Yes
    - No

36. Do you have an amputated limb?
    - Yes
    - No

    a. If yes, do you have numbness or tingling at the site of your amputation or do you feel like your limb is still there?
        - Yes
        - No

37. Have you been diagnosed with diabetes?
    - Yes
    - No

    a. If Yes – When was your last dilated eye exam?
    - Within the last year
    - Over a year ago
    - I don't know
    - I have never had this exam

    b. If Yes – When were your feet last examined?
    - Within the last year
    - Over a year ago
    - I don't know
    - I have never had this exam

    c. If Yes – Are you on medication to control your cholesterol?
    - Yes
    - No

    d. If Yes – Do you have numbness or tingling in your lower limbs or feet?
    - Yes
    - No