

Annual Wellness Questionnaire

Personal Information

Name *

First Name

Last Name

Date of Birth *

 

Date

Phone Number *

Number

Type

Owner

+

Email *

example@example.com

Section 1 COA/SDOH

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. Within the past 12 months have you ever stayed outside in a car, in a tent, in an overnight shelter, or temporarily inside someone else's home (i.e. couch surfing)? *

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 to 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

14a. If Yes - What type of device do you use?

- Cane
- Walker
- Wheel Chair
- Other

14b. 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 and housework, eating without help, or getting around your home? *

- No
- Yes

19b. If yes, please select all that apply: *

- Transportation
- Shopping
- Grooming or bathing
- Preparing meals
- Housework
- Eating without help
- Getting around your home
- Other

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, eating well, teeth or dentures, using the telephone, tired or fatigued? *

- No
- Yes

22b. If yes, please select all that apply: *

- Sexual problems
- Trouble eating well
- Teeth or dentures
- Using telephone
- Tired or fatigue
- Other

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? *

- Excellent
- Very good
- Good
- Fair
- Poor

28. Have you been to the emergency room 2 or more times in the last 12 months? *

- Yes
- No

29. Have you been admitted to the hospital in the last 12 months? *

- Yes
- No

30. How often do you have trouble taking medicine the way you have been told to take your medicine. *

- I don't take medicine
- I always take my medicine as prescribed
- I sometimes take my medicine as prescribed
- I seldom take my medicine as prescribed

31. Do you have any Advanced Directives? *

- Yes
- No

31a. If Yes, what do you have in place.

- Living Will
- Actionable medical order/Do Not Resuscitate
- Designated Healthcare surrogate or proxy

32. Have you ever had a stroke? *

- Yes
- No

32a. If Yes - Do you have any residual side effects?

- Face impairment
- Arm or limb weakness or numbness
- Visual difficulties
- Speech impairment or slurring
- None
- Other

33. Do you have a joint replacement? *

- Yes
- No

33a. If Yes - Which joint(s) have been replaced?

- Knee
- Hip
- Other

33b. 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

34a. 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

36a. 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

37a. 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

37b. 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

37c. If Yes - Are you on medication to control your cholesterol?

Yes

No

37d. If Yes - Do you have numbness or tingling in your lower limbs or feet?

Yes

No