MaxHealth

English (US)

Annual Wellness Questionnaire

Personal Information

Name *

First Name

Last Name

Date of Birth *

MM-DD-YYYY

Date

Phone Number *

Number	Type	Owner
000-000-0000	Please Select	Please Select

+

Email *

example@example.com

Section 1A SDOH

1. Within the past 12 months did you worry that your food would run out before you got money to buy more? *

- Yes
- No

2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more? *

- Yes
- No

3. 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

4. Are you worried about losing your housing? *

- Yes
- No

5. 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

6. 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

7. Do you feel physically and emotionally safe where you currently live? *

- ◯ Yes
- ◯ No

8. Within the past 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by someone? *

- ◯ Yes
- ◯ No

9. Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? *

- ◯ Yes
- ◯ No

Section 1B COA

1. Employment Status *

- ◯ Employed
- ◯ Retired
- ◯ Medically unable to work
- ◯ Unemployed

2. In the last 4 weeks, how often did you have trouble paying for medication? *

- ○ Never
- ○ Occasionally
- ○ Sometimes
- ○ Often
- ○ All the time

3. During the past 4 weeks, how much bodily pain have you had? *

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

4. 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

5. 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

6. Do you use an assistive device for walking? *

- ◯ Yes
- ◯ No

6a. If Yes - What type of device do you use?

- ☐ Cane
- ☐ Walker
- ☐ Wheel Chair
- ☐ Other

6b. If Yes - How often do you use your assistive device

- ☐ All the time
- ☐ Quite often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

7. Do you have a hearing impairment that requires special equipment? *

- Yes
- No

8. Do you have difficulty seeing and recognizing an object at arm's length or difficulty reading? *

- Yes
- No

9. Do you have difficulty starting and focusing on maintaining a conversation? *

- Yes
- No

10. 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

11. Do you struggle with transportation, shopping, grooming or bathing, preparing meals and housework, eating without help, or getting around your home? *

- No
- Yes

11b. If yes, please select all that apply: *

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

12. Are you having difficulties driving your car? *

- ( ) Yes, often
- ( ) Sometimes
- ( ) No, never
- ( ) Don't drive a car

13. 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

13b. If yes, please select all that apply: *

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

Section 2: HOS

1. 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

2. Have you fallen 2 or more times in the past 12 months? *

- ( ) Yes
- ( ) No

3. Are you afraid of falling. *

- ( ) Yes
- ( ) No

4. Do you have any bladder control or issue with urine leakage? *

- ( ) Yes
- ( ) No

Section 3: Wellness

1. During the past 4 weeks, how would you rate your health in general? *

- ( ) Excellent
- ( ) Very good
- ( ) Good
- ( ) Fair
- ( ) Poor

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

- ◯ Yes
- ◯ No

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

- ◯ Yes
- ◯ No

4. 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

5. Do you have any Advanced Directives? *

- ◯ Yes
- ◯ No

5a. If Yes, what do you have in place.

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

6. Have you ever had a stroke? *

- ◯ Yes
- ◯ No

6a. 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

7. Do you have a joint replacement? *

- ( ) Yes
- ( ) No

7a. If Yes - Which joint(s) have been replaced?

- [ ] Knee
- [ ] Hip
- [ ] Other

7b. If Yes - Do you have any pain in the replaced joint?

- ( ) Yes
- ( ) No

8. Have you ever been diagnosed with COPD (Chronic Obstructive Pulmonary Disease)? *

- ( ) Yes
- ( ) No

8a. 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

9. Are you on oxygen therapy? *

- ( ) Yes
- ( ) No

10. Do you have an amputated limb? *

- ( ) Yes
- ( ) No

10a. 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

11. Have you been diagnosed with diabetes? *

- ( ) Yes
- ( ) No

11a. 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

11b. 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

11c. If Yes - Are you on medication to control your cholesterol?

- ( ) Yes
- ( ) No

11d. If Yes - Do you have numbness or tingling in your lower limbs or feet?

- ( ) Yes
- ( ) No

Submit