# Dr. Lakin's Pre-Physical/Wellness Visit Forms
**PLEASE PRINT**

Date: _____

Name: _____ Date of Birth: _____

**Social History:**
Tobacco use: YES _____ NO _____ How Much? _____

Alcohol Use: YES _____ NO _____ How much? _____

**Allergies:** _____

**Are you having a problem with?**

Abdominal/stomach YES _____ NO _____ Bladder/urinary YES _____ NO _____

Breathing/lungs YES _____ NO _____ Heart/vascular YES _____ NO _____

Nerves/unusual sensations YES _____ NO _____

Other concerns to discuss today: _____

**Do you wish to discuss advanced care planning (end of life)?** YES _____ NO _____

**Names of other specialists you see:**

Cardiology: _____ Dermatology: _____

Gastroenterology: _____ Gynecology: _____

Oncology: _____ Ophthalmology: _____

Pulmonology: _____ Surgeon: _____

Urology: _____ Other: _____

**Family Medical History:**

Father: _____ Mother: _____

Brother: _____ Sister: _____

Signature: _____

# Fall Risk Questionnaire and Physician Guide

## Desmond Fall Risk Questionnaire

*Please answer all questions*

Name _____ Date _____

1. ___Yes / No___ Have you had a fall or near fall in the past year?
2. ___Yes / No___ Do you have a fear of falling that restricts your activity?
3 ___Yes / No___ Do you experience dizziness or a sensation of spinning when you lie down, tilt your head back, or roll over in bed?
4. ___Yes / No___ Do you feel uneasy or unsteady when walking down the aisle of a supermarket or in an area congested with other people?
5. ___Yes / No___ Do your feet or toes frequently feel unusually hot or cold, numb or tingly?
6. ___Yes / No___ Do you wear bifocal or trifocal glasses, or is your vision notably better in one eye?
7. ___Yes / No___ Do you experience loss of balance, or a lightheaded/faintfeeling when you stand up?
8. ___Yes / No___ Do you take medication for depression, anxiety, nerves, sleep or pain?
9. ___Yes / No___ Do you take four or more prescription medications daily?
10. ___Yes / No___ Do you feel like your feet just won't go where you them to go?
12. ___Yes / No___ Do you feel like you can't walk a straight line, or are pulled to the side while walking?
13. ___Yes / No___ Has it been longer than six months since you participated in a regular exercise program?
14. ___Yes / No___ Do you feel that no one really understands how much dizziness and balance problems affect your quality of life?
15. ___Yes / No___ Are you interested in improving your balance and mobility?

**Patient Name:_____ Date:_____**
**Patient ID #_____**

# Katz Index of Independence in Activities of Daily Living

| **Activities**<br>Points (1 or 0) | **Independence**<br>(1 Point)<br><br>**NO** supervision, direction or personal assistance. | **Dependence**<br>(0 Points)<br><br>**WITH** supervision, direction, personal assistance or total care. |
|---|---|---|
| **BATHING**<br><br>Points: _____ | **(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity. | **(0 POINTS)** Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing |
| **DRESSING**<br><br>Points: _____ | **(1 POINT)** Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes. | **(0 POINTS)** Needs help with dressing self or needs to be completely dressed. |
| **TOILETING**<br><br>Points: _____ | **(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help. | **(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode. |
| **TRANSFERRING**<br><br>Points: _____ | **(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable | **(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer. |
| **CONTINENCE**<br><br>Points: _____ | **(1 POINT)** Exercises complete self control over urination and defecation. | **(0 POINTS)** Is partially or totally incontinent of bowel or bladder |
| **FEEDING**<br><br>Points: _____ | **(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person. | **(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding. |

**TOTAL POINTS: _____** **SCORING:** 6 = High (*patient independent*) 0 = Low (*patient very dependent*

Source:
*try this:* Best Practices in Nursing Care to Older Adults, The Hartford Institute for Geriatric Nursing, New York University, College of Nursing, www.hartfordign.org.

# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
*(use "✓" to indicate your answer)*

| | Not at all | Several days | More than half the 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 or 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 are 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 so slowly that other people could have noticed. Or the opposite — being so figety 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 | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| | | add columns | + | + |

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).* TOTAL:

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