Name:

_____ Date: _____

Date of Birth: _____

Activities of Daily Living Checklist

ADLs & IADLs	Require no assistance	Require some assistance	Complete assistance needed	Not Applicable
Bathing				
Dressing				
Grooming				
Oral Care				
Toileting				
Transferring				
Walking				
Climbing Stairs				
Eating				
Shopping				
Cooking				
Managing Medications				
Uses The Phone				
Housework				
Laundry				
Driving				
Managing Finances				
Totals:				

Name:Date:Date:				
Over the last 2 weeks, how often have you been bothered by any of the following problems? Circle a number 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 fidgety 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 in some way	0	1	2	3

Date:

Total Score_____ = ____+____+____+_____+_____

Name:

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

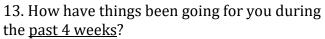
Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission.

A Checklist for Your Medicare Wellness Annual Visit

Please complete this checklist before seeing your doctor or nurse. Your answers will help you receive the best health care possible.

 During the <u>past 4 weeks</u>, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue? Not at all Slightly Moderately Quite a bit Extremely 	 5 During the <u>past 4 weeks</u>, what weeks, what we physical activity you could do for minutes? Very heavy Heavy Moderate Light Very light 		
		Yes	No
2. During the <u>past 4 weeks</u> , has your physical and emotional health limited your social activities with family friends, neighbors or groups?	6. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?		
 □ Slightly □ Moderately 	7. Can you shop for groceries or clothes without help?		
 Quite a bit Extremely 	8. Can you prepare your own meals?		
3. During the <u>past 4 weeks</u> , how much bodily	9. Can you do your own housework without help?		
pain have you generally had?	10. Can you handle your own money without help?		
 Very mild pain Mild pain Moderate pain 	11. Do you need help eating, bathing, dressing, or getting around your home?		
☐ Severe pain 4. During the <u>past 4 weeks</u> , was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of	 12. During the <u>past 4 weeks</u>, how your health in general? Excellent Very good Good Fair Poor 	would yc	ou rate

- □ Yes, as much as I wanted
- □ Yes, quite a bit
- ☐ Yes, some
- 🗆 Yes, a little
- \Box No, not at all



- □ Very well could hardly be better
- □ Pretty good
- □ Good and bad parts about equal
- □ Pretty bad
- □ Very bad could hardly be worse



yourself.

14. Are you having difficulties driving your car?

🗆 Yes, often

- □ Sometimes
- 🗆 No
- 🗆 Not applicable, I do not use a car

15. Do you always fasten your seat belt when you are in a car?

 \Box Yes, usually \Box Yes, sometimes \Box No

16. How often during the <u>past 4 weeks</u> have you been <u>bothered</u> by any of the following problems?

	Never	Seldom	Sometimes	0ften	Always
Fall or dizzy when standing up					
Sexual problems					
Trouble eating well					
Teeth or dentures					
Problems using the telephone					
Tired or fatigued					

17. Have you fallen 2 or more times in the past year?

 \Box Yes \Box No

18. Are you afraid of falling?

Yes No

19. Are you a smoker?

🗆 No

- □ Yes, and I might quit
- □ Yes, but I'm not ready to quit

20. During the <u>past 4 weeks</u>, how many drinks of wine, beer or other alcoholic beverages did you have?

- \square 10 or more per week
- ☐ 6-9 per week
- 2-5 per week
- □ 1 drink or less per week
 - No alcohol at all

21. Do you exercise for about 20 minutes 3 or more days a week?

- $\hfill\square$ Yes, most of the time
- $\hfill\square$ Yes, some of the time
- □ No, I usually do not exercise this much.

22. Have you been given any information to help you with the following:

- Hazards in your house that might hurt you?
 □ Yes □ No
- Keeping track of your medications?
 □ Yes □ No

23. How often do you have trouble taking medicines the way you have been told to take them?

- $\hfill\square$ I do not have to take medicine
- □ I always take them as prescribed
- $\hfill\square$ Sometimes I take them as prescribed
- $\hfill\square$ I seldom take them as prescribed

24. How confident are you that you can control and manage most of your health problems?

- UVery confident
- □ Somewhat confident
- 🗆 Not very confident
- \Box I do not have any health problems.

How old are you? \Box 65-69 70-79 80 or older		
Are you male or female? Male Female		
What is your race? (check one or more than one)		
🗆 Black/African American		
🗆 Asian		
Native Hawaiian/Other Pacific Islander		
🗆 American Indian/Alaskan Native		
Hispanic or Latino origin or descent		
□ Other		

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