Today's Date: _____

Patient Name: _____

COASTAL HEALTHCARE

Annual Wellness Visit Health Risk Assessment

Personal Information

1. Preferred Pharmacy: _____
2. Preferred Lab: _____
3. Preferred imaging and x-ray facility: _____

Care Team

Specialty	Physician Name	Last Seen
Cardiology		
Dentist		
Dermatologist		
Ear, Nose & Throat (ENT)		
Endocrinologist		
Eye/Optometry/Ophthalmologist		
Gastroenterologist		
Gynecologist		
Hematologist/Oncologist		
Nephrologist		
Neurologist		
Orthopedist		
Podiatrist		
Pulmonologist		
Psychiatrist/Psychologist		
Rheumatologist		
Urologist		
Other:		

Have you seen a dentist within the last 6 months:	Yes	No

Pain Assessment

In the past 2 weeks, how often have you felt pain?

Never	Almost never	Sometimes	Most times	Almost all of the time

Where is the pain? _____

Rate your pain on the following scale:

1 🙂 | 2 😊 | 3 😐 | 4 😟 | 5 😣 | 6 😖 | 7 😫 | 8 😩 | 9 😭 | 10 🤯

Allergies – Drugs, Food Environment

Medications – Prescriptions, Vitamins, Over-the-Counter

Name	Dose	Name	Dose

Self & Family History *(mark the columns that apply)*

	None	Self	Parent	Brother	Sister	Child
Congestive Heart Failure						
Diabetes						
COPD (Chronic Lung Disease) or Asthma						
Hypertension						
Stroke						
Kidney Disease						
Obesity						
Liver Disease						
Bipolar Disorder or Schizophrenia						
Dementia						
Cancer						
Depression						
Significant Surgeries:						

Functional Status Assessment

Are you able to care for yourself independently?	Yes	No	Note:
Are you blind or do you have difficulty seeing?	Yes	No	Note:
Are you use eyeglasses or contacts?	Yes	No	Note:
Are you deaf or have serious difficulty hearing?	Yes	No	Note:
Do you use hearing aids or other devices?	Yes	No	Note:
Do you have difficulty concentrating, remembering or making decisions?	Yes	No	Note:
Do you have difficulty walking or climbing stairs?	Yes	No	Note:
Do you have difficulty dressing, bathing, grooming or toileting?	Yes	No	Note:
Do you have difficulty doing errands alone?	Yes	No	Note:
Do you have transportation difficulties?	Yes	No	Note:

Physical Activity

How many days a week do you exercise?	0	1-2	3-4	5+	I don't know	
How intense is your exercise?	Light	Moderate	Heavy	Very Heavy	I don't know	I don't exercise

Tobacco, Alcohol and Drug Use

Do you use any tobacco products? (Cigarettes, chew, snuff, pipes, cigar)	Yes	No

If so, are you interested in quitting tobacco?	Yes	No	I don't use tobacco

How many times in the past year have you had 4 or more drinks in a day?	Never	Moderate	Heavy	Number of days:

Do you use any illegal drugs or take any prescription medications that have not been prescribed to you?	No	Yes (please describe):

Advance Directives

Does your family or friends know what you want in an emergency situation or if you could not speak for yourself:

No | Yes and I have completed (*mark all that apply):*

	A living will (Advance Directive)
	DNR
	Power of Attorney for Health Care
	POLST (in some states known as: POST, MOST, MOSLST, TPOPP)
	Five wishes

Would you like more information?

Yes	No	Unsure

Home/Safety

What is your housing situation like? (*mark all that apply):*

	Live with one or more children or dependent
	Live in an assisted living facility
	Live alone
	I have housing today, but I am worried about losing housing in the future
	I do not have housing (I am staying with others, on a beach, in a car, abandoned building, bus or train station or in a park

Social/Emotional Support

Which of the following applies to you? (*mark all that apply):*

	I have a supportive family
	I have supportive friends
	I participate in church, clubs, or other groups
	None

Would you like more information?

Yes	No	Unsure

Sleep

How many hours of sleep do you usually get?	0-3	4-6	7-10	I don't know
Do you snore, or has anyone told you that you snore?	Yes	No	I don't know	
In the past 7 days, how often have you felt sleepy during the day?	Often	Sometimes	Almost Never	Never
Have you ever been diagnosed with Sleep Apnea or other sleep disorders?	Yes	No	I don't know	
Are you currently using or have you used C-PAP/Bi-PAP?	Yes	No		

Depression Screening (PHQ-2)

In the past 2 weeks, how often have you been bothered by the following problems:	Not at all	Several Days:	More than half of those days:	Nearly every day:
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Total Score: _____

Steady Fall Risk (*mark all that apply):*

Yes	No	I have fallen in the past year
Yes	No	I use or have been advised to use a can or walker to get around safely
Yes	No	Sometimes I feel unsteady when I am walking
Yes	No	I steady myself by holding onto furniture when walking at home
Yes	No	I am worried about falling
Yes	No	I need to push with my hands to stand up from a chair
Yes	No	I have some trouble stepping up onto a curb
Yes	No	I often have to rush to the toilet
Yes	No	I have lost some feeling in my feet
Yes	No	I take medicine that sometimes makes me feel light-headed or more tired than usual
Yes	No	I take medicine to help me sleep or improve my mood
Yes	No	I often feel sad or depressed

Total Score: _____

Do you have a problem with the following at your home? (*mark all that apply):*

	Bug infestation
	Mold
	Lead pain or pipes
	Inadequate heat
	Oven or stove not working
	No or not working smoke detectors
	Water leaks
	None of the above

Do you feel safe in your home?	Yes	No	
Does your home have working smoke alarms?	Yes	No	I don't know
Do you have area rugs on your floor(s)?	Yes	No	
Do you have handrails in the bathroom?	Yes	No	
Do you have proper lighting in your home?	Yes	No	
Do you have handrails for the stairs?	Yes	No	I don't have stairs
Do you fasten your seatbelt in vehicles?	Yes	No	I don't ride in vehicles

Adverse Childhood Experience Questionnaire for Adults

California Surgeon General's Clinical Advisory Committee

aces aware
SCREEN. TREAT. HEAL.

Our relationships and experiences—even those in childhood—can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: Below is a list of 10 categories of Adverse Childhood Experiences (ACEs). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the *total number* at the bottom.

1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	
2. Did you lose a parent through divorce, abandonment, death, or other reason?	
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	
6. Did you live with anyone who went to jail or prison?	
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	
9. Did you feel that no one in your family loved you or thought you were special?	
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health? **Not Much** **Some** **A Lot**

Experiences in childhood are just one part of a person's life story.
There are many ways to heal throughout one's life.

Please let us know if you have questions about privacy or confidentiality.

5/5/20

NIDA Clinical Trials Network
The Tobacco, Alcohol, Prescription medications, and other Substance (TAPS) Tool

TAPS Tool Part 1

Web Version: 2.0; 4.00; 09-19-17

General Instructions:
The TAPS Tool Part 1 is a 4-item screening for tobacco use, alcohol use, prescription medication misuse, and illicit substance use in the past year. Question 2 should be answered only by males and Question 3 only be females. Each of the four multiple-choice items has five possible responses to choose from. Check the box to select your answer.

Segment:
Visit number:

1. In the PAST 12 MONTHS, how often have you used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

2. In the PAST 12 MONTHS, how often have you had 5 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by males).

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

3. In the PAST 12 MONTHS, how often have you had 4 or more drinks containing alcohol in one day? One standard drink is about 1 small glass of wine (5 oz), 1 beer (12 oz), or 1 single shot of liquor. (Note: This question should only be answered by females).

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

4. In the PAST 12 MONTHS, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

5. In the PAST 12 MONTHS, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you? Prescription medications that may be used this way include: Opiate pain relievers (for example, OxyContin, Vicodin, Percocet, Methadone) Medications for anxiety or sleeping (for example, Xanax, Ativan, Klonopin) Medications for ADHD (for example, Adderall or Ritalin)

   ☐ Daily or Almost Daily ☐ Weekly ☐ Monthly
   ☐ Less Than Monthly ☐ Never

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

PRAPARE®: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

Paper Version of PRAPARE® for Implementation as of September 2, 2016

Personal Characteristics

1. Are you Hispanic or Latino?

	Yes		No		I choose not to answer this question

2. Which race(s) are you? Check all that apply

	Asian		Native Hawaiian
	Pacific Islander		Black/African American
	White		American Indian/Alaskan Native
	Other (please write):		
	I choose not to answer this question		

3. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?

	Yes		No		I choose not to answer this question

4. Have you been discharged from the armed forces of the United States?

	Yes		No		I choose not to answer this question

5. What language are you most comfortable speaking?

Family & Home

6. How many family members, including yourself, do you currently live with? _____

	I choose not to answer this question

7. What is your housing situation today?

	I have housing
	I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)
	I choose not to answer this question

8. Are you worried about losing your housing?

	Yes		No		I choose not to answer this question

9. What address do you live at?
Street:_____
City, State, Zip code: _____

Money & Resources

10. What is the highest level of school that you have finished?

	Less than high school degree		High school diploma or GED
	More than high school		I choose not to answer this question

11. What is your current work situation?

	Unemployed		Part-time or temporary work		Full-time work
	Otherwise unemployed but not seeking work (ex: student, retired, disabled, unpaid primary care giver) Please write:				
	I choose not to answer this question				

12. What is your main insurance?

	None/uninsured		Medicaid
	CHIP Medicaid		Medicare
	Other public insurance (not CHIP)		Other Public Insurance (CHIP)
	Private Insurance		

13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

_____

	I choose not to answer this question

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PRAPARE
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14. In the past year, have you or any family members you live with been **unable** to get any of the following when it was **really needed**? Check all that apply.

Yes	No	Food	Yes	No	Clothing
Yes	No	Utilities	Yes	No	Child Care
Yes	No	Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)			
Yes	No	Phone	Yes	No	Other (please write):
	I choose not to answer this question				

15. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

	Yes, it has kept me from medical appointments or
	Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
	No
	I choose not to answer this question

Social and Emotional Health

16. How often do you see or talk to people that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

	Less than once a		1 or 2 times a week
	3 to 5 times a week		5 or more times a
	I choose not to answer this question		

17. Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

	Not at all		A little bit
	Somewhat		Quite a bit
	Very much		I choose not to answer this question

Optional Additional Questions

18. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

	Yes		No		I choose not to answer this

19. Are you a refugee?

	Yes		No		I choose not to answer this

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

	Yes		No		Unsure
	I choose not to answer this question				

21. In the past year, have you been afraid of your partner or ex-partner?

	Yes		No		Unsure
	I have not had a partner in the past year				
	I choose not to answer this question				

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PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, 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

Office use only: **Severity score:** _____

Johnson JG, Harris ES, Spitzer RL, Williams JB. The patient health questionnaire for adolescents: validation of an instrument for the assessment of mental disorders among adolescent primary care patients. J Adolesc Health. 2002;30(3):196-204. doi:10.1016/s1054-139x(01)00333-0

asQ
Ask Suicide-Screening Questions

Ask the patient:

(1) In the past few weeks, have you wished you were dead? YES NO

(2) In the past few weeks, have you felt that you or your family would be better off if you were dead? YES NO

(3) In the past week, have you been having thoughts about killing yourself? YES NO

(4) Have you ever tried to kill yourself? YES NO

If yes, how? _____ When? _____

If the patient answers yes to any of the above, ask the following question:

(5) Are you having thoughts of killing yourself right now? YES NO

If yes, please describe: _____

Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. Arch Pediatr Adolesc Med. 2012;166(12):1170-1176. doi:10.1001/archpediatrics.2012.1276

Provide resources to all patients: 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
24/7 Crisis Text Line: Text "HOME" to 741-741

SBQ-R Suicide Behaviors Questionnaire-Revised

Patient Name _____ Date of Visit _____

Instructions: Please check the number beside the statement or phrase that best applies to you.

1. Have you ever thought about or attempted to kill yourself? (check one only)

- ☐ 1. Never
- ☐ 2. It was just a brief passing thought
- ☐ 3a. I have had a plan at least once to kill myself but did not try to do it
- ☐ 3b. I have had a plan at least once to kill myself and really wanted to die
- ☐ 4a. I have attempted to kill myself, but did not want to die
- ☐ 4b. I have attempted to kill myself, and really hoped to die

2. How often have you thought about killing yourself in the past year? (check one only)

- ☐ 1. Never
- ☐ 2. Rarely (1 time)
- ☐ 3. Sometimes (2 times)
- ☐ 4. Often (3-4 times)
- ☐ 5. Very Often (5 or more times)

3. Have you ever told someone that you were going to commit suicide, or that you might do it? (check one only)

- ☐ 1. No
- ☐ 2a. Yes, at one time, but did not really want to die
- ☐ 2b. Yes, at one time, and really wanted to die
- ☐ 3a. Yes, more than once, but did not want to do it
- ☐ 3b. Yes, more than once, and really wanted to do it

4. How likely is it that you will attempt suicide someday? (check one only)

- ☐ 0. Never
- ☐ 1. No chance at all
- ☐ 2. Rather unlikely
- ☐ 3. Unlikely
- ☐ 4. Likely
- ☐ 5. Rather likely
- ☐ 6. Very likely

This questionnaire is intended for female patients ages 21–41.
Please complete if applicable

Extended–Hurt, Insulted, Threaten, Scream (E-HITS)

Over the last 12 months, how often did your partner:

	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Frequently (5)
1. Physically hurt you?	❑	❑	❑	❑	❑
2. Insult your or talk down to you?	❑	❑	❑	❑	❑
3. Threaten you with harm?	❑	❑	❑	❑	❑
4. Scream or curse at you?	❑	❑	❑	❑	❑
5. Force you to have sexual activities?	❑	❑	❑	❑	❑

Score range: 5–25
Cutoff for IPV: ≥7

Iverson KM, King MW, Gerber MR, et al. Accuracy of an intimate partner violence screening tool for female VHA patients: a replication and extension. *J Trauma Stress*. 2015 Feb;28(1):79–82. doi: 10.1002/jts.21985 [doi]. PMID: 25624170. [PubMed] [CrossRef]