Patient Health Assessment

Please complete these questions before your visit. Your answers will help us provide you the best care possible.

Patient Name: ________________________________ **DOB:** ____________________

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

GAD-2	**Over the past 2 weeks, how often have you been bothered by any of the following problems?**	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
	Feeling anxious, nervous or on edge	0	1	2	3
	Not being able to stop or control worrying	0	1	2	3

CAGE			
	Have you ever felt you should cut down on your drinking?	Yes	No
	Have people annoyed you by criticizing your drinking?	Yes	No
	Have you ever felt bad or guilty about your drinking?	Yes	No
	Have you ever had a drink as an eye-opener first thing in the morning to steady your nerves or help a hangover?	Yes	No

SOCIAL NEEDS ASSESSMENT			
	Do you/your family worry about whether your food will run out and you won't be able to get more?	Yes	No
	Are you worried about losing your housing, or are you homeless?	Yes	No
	Are you currently having issues at home with your utilities such as your heat, electric, natural gas, or water?	Yes	No
	Has a lack of transportation kept you from attending medical appointments or from work, or from getting things you need for daily living?	Yes	No
	Are you worried that someone may hurt you or your family?	Yes	No
	In the last 12 months, did you skip medications to save money?	Yes	No

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FALLS RISK			
	Have you fallen in the past year?	Yes	No
	If yes, how many times?	______ time(s)	
	Were you injured?	Yes	No
	Do you worry about falling?	Yes	No
	Do you feel unsteady when standing or walking?	Yes	No