Patient Name____ DOB__________________

Date___________

PHQ-2: Initial Screening

Over the past two 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**

Total Score: __________

Activities of Daily Living (ADL)

Information obtained from Patient _____ Information obtained from other person ______ Who? ________________

Using Telephone	I = Able to look up numbers, dial, receive and make calls without help A = Able to answer phone or dial operator in an emergency but needs special phone or help in getting number, dialing D = Unable to use telephone
Traveling	I = Able to drive own care or travel alone on buses, taxis A = Able to travel but needs someone to travel with D = Unable to travel
Shopping	I = Able to take care of all food/clothes A = Able to shop but needs someone to shop with D = Unable to Shop
Preparing Meals	I = Able to plan and cook full meals A = Able to prepare light foods but unable to cook full meals alone D = Unable to prepare any meals
Housework	I = Able to do heavy housework, (i.e. scrub floors) A = Able to do light housework, but needs help with heavy tasks D = Unable to do any housework
Taking Medicines	I = Able to prepare/take medications in the right dose at the right time A = Able to take medications, but needs reminding or someone to prepare them D = Unable to take medications
Managing Money	I = Able to manage buying needs, (i.e. write checks, pay bills) A = Able to manage daily buying needs but needs help managing checkbook, paying bills D = Unable to manage money

I= Independent ***A = Assistance Required*** ***D = Dependent***

Hearing

Do you have a hearing problem now? ☐ **YES** ☐ **NO**

Patient Name____ DOB__________________

Date___________

Safety & Fall Risk Assessment

1.	Have you fallen in the past 6 months?	**YES**	**NO**
2.	If you answered YES to question #1, were you injured?	**YES**	**NO**
3.	Have you experienced urgency or frequency with elimination in the past 6 months?	**YES**	**NO**
4.	Have you experienced episodes of dizziness in the past 6 months?	**YES**	**NO**
5.	Do you use any assistive devices for ambulation? If you answered YES, please circle the device(s) used: a) another person; b) railing; c) cane; d) walker; e) wheelchair	**YES**	**NO**
6.	Do you feel you could benefit from installing grab bars on your tub and/or shower?	**YES**	**NO**
7.	Does your home lack smoke detectors or sprinklers?	**YES**	**NO**
8.	Do you sometimes forget to fasten your seat belt when traveling in a car?	**YES**	**NO**
9.	Does your home have a fireplace?	**YES**	**NO**
10.	Do you smoke?	**YES**	**NO**
11.	Do you drink alcohol at least twice a week?	**YES**	**NO**
12.	Do you use oxygen on a regular basis?	**YES**	**NO**
13.	Does your home lack fire extinguishers?	**YES**	**NO**
14.	Do you use scatter rugs throughout your home?	**YES**	**NO**
15.	Does your home have a pool or hot tub?	**YES**	**NO**