2021 PATIENT ASSESSMENT REQUIREMENTS

NEW RULES for 2021

1. As of 2021 ALL insurance companies including Medicare and Medicaid now require ALL patients to complete a short assessment series annually.
2. There is no cost to the patient, and no deductible or copay is required.
3. These assessments only take about 8-10 minutes and can be done on your own devices in the comfort of your home, in our waiting room, may download a paper version, or may ask our staff to call you and ask you the questions.
4. Failure to participate will create financial penalties for the physician.
5. Failure by the patient to complete these required assessments may temporarily limit or delay some access to patient services such as prescription refills and other orders.
6. It's important to you and your family that we stay ahead of potential health risks!
7. Please respond promptly to your Personal Health Coach who will share your results with you.

Thank you in advance!

Date: Time: Existing Patient _____ New Patient_____

Patient Name: Gender_____

Patient Address

Patient DOB:

Patient Mobile Number: Patient Email Address:

Patient Home Number:

List Current Medications: N/A – On file

List any chief or new complaints or health problems:

SAFETY RISK ASSESSMENT – Required of All Patients

1-Do you ever think about dying?

Yes No

2-Do you ever think about killing yourself, or wish you were dead?

Yes No

If yes above:

3-When you think about dying, do you have a plan about how to do it?

Yes No

4-Do you have means to carry out your plan?

Yes No

5-History of previous suicide attempts

Yes No

6-Suicide / Homicide risk:

Low risk

No current thoughts of harm to self or others no history of suicide attempt

Medium Risk

Current thoughts of harm, but no plan with or without of suicide attempt

High Risk

7-Current thoughts of harm with plan?

Health Risk Assessment (HRA)

1. Physical Activity
In the past 7 days, how many days did you exercise?
_____days
2. Tobacco Use
In the last 30 days, have you used tobacco in any form?
_____Yes
_____No

3. Alcohol Use
In the past 7 days, how many drinks have you had that contain alcohol?
_____Drinks

4. Seat Belt Use
Do you always fasten your seat belt when you are in a car?
_____Yes
_____No

5. Life satisfaction
In the past 2 weeks, how often have you felt down, depressed, or hopeless?
_____Almost all of the time
_____Most of the time
_____Some of the time
_____Almost never

6. Anxiety
In the past 2 weeks, how often have you felt nervous, anxious, or on edge?
_____Almost all of the time
_____Most of the time
_____Some of the time
_____Almost never
7. Stress
How often is stress a problem for you in handling such things such as health, finances, family or social relationships or work?
_____Never or rarely
_____Sometimes
_____Often
_____Always

8. Pain
In the past 7 days, how much pain have you felt?
_____None
_____Some
_____A lot

9. General Health
In general, would you say your health is
_____Excellent
_____Very good
_____Good
_____Fair
_____Poor

10. Sleep
Each night, how many hours of sleep do you usually get?
_____Hours

11. Blood Pressure
If your blood pressure was checked within the past year, what was it when it was last checked?
_____Low or normal (at or below 120/80)
_____Borderline high (120/80 to 139/89)
_____High (140/90 or higher)
_____Don't know/not sure

12. Cholesterol
If your cholesterol was checked within the past year, what was your total cholesterol when it was last checked?
_____Desirable (below 200)
_____Borderline high (200–239)
_____High (240 or higher)
_____Don't know/not sure

13. Blood Glucose
If your glucose was checked, what was your fasting blood glucose (blood sugar) level the last time it was checked?
_____Desirable (below 100)
_____Borderline high (100–125)
_____High (126 or higher)
_____Don't know/not sure

14. Hemoglobin A1c level
If diabetic, and if you have had your hemoglobin A1c level checked in the past year, what was it the last time you had it checked?
_____Desirable (6 or lower)
_____Borderline high (7)
_____High (8 or higher)
_____Not a Diabetic

15. Overweight/Obesity
What is your height?

_____Feet _____Inches _____Weight in pounds

Annual Wellness Questions

1. Please list all doctors that you have seen in the past year and the specialty N/A – On file
2. Please list all any medications you are currently taking N/A – On file
3. Please list any tests you have done in the past year such as blood tests, colonoscopy, mammograms, CT Scan, MRI, etc N/A – On file

4. Have you had any recent immunizations?

   Yes_____ No_____

5. Do you have a living will or advance directive?

   Yes_____ No_____

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?

   Yes_____ No_____

7. Can you shop for groceries or clothes without help?

   Yes_____ No_____

8. Can you prepare your own meals?

   Yes_____ No_____

9. Can you do your own housework without help?

   Yes_____ No_____

10. Can you handle your own money without help?

    Yes_____ No_____

11. Do you need help eating, bathing, dressing, or getting around your home?

    Yes_____ No_____

12. Have you been given any information to help you keep track of your medications?

    Yes_____ No_____

13. Have you been given any information to help you identify hazards in your house that might hurt you?

    Yes_____ No_____

14. Have you fallen two (2) or more times in the past year?

    Yes_____ No_____

15. How often in the past 4 weeks, have you had problems using the telephone?

    Never_____ Seldom_____ Sometimes_____ Often_____

16. How often in the past 4 weeks, have you had trouble eating well?

    Never_____ Seldom_____ Sometimes_____ Often_____

17. How often in the past 4 weeks, have you been bothered by your teeth or dentures?

    Never_____ Seldom_____ Sometimes_____ Often_____

18. During the past 4 weeks, 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 yourself.

    Yes as much as I wanted_____ Yes, Quite a bit_____ Yes, Some_____ Yes, a little_____ No, Not at all_____

19. Are you having difficulties driving your car?

    No_____ Sometimes_____ yes, Often_____ Not applicable, I do not use a car

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

    Very Confident_____ Somewhat Confident_____ Not very confident_____ I do not have any health problems_____

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

    I do not have to take medicine_____ I always take them as prescribed_____ Sometimes I take them as prescribed_____ I seldom take them as prescribed_____

22. Do any family members have a personal history with any health issues, please list below.

Generalized Anxiety (GAD7)

Over the last 2 weeks, how often have you been bothered by the following problems?

1. Feeling nervous, anxious or on edge?

Not at all_____ Several days_____ More than half the days_____ Nearly every day_____

2. Not being able to stop or control worrying?

Not at all_____ Several days_____ More than half the days_____ Nearly every day_____

3. Worrying too much about different things?

Not at all_____ Several days_____ More than half the days_____ Nearly every day_____

4. Trouble relaxing?

Not at all_____ Several days_____ More than half the days_____ Nearly every day_____

5. Being so restless that it is hard to sit still?

Not at all_____ Several days_____ More than half the days_____ Nearly every day_____

6. Becoming easily annoyed or irritable?

Not at all_____ Several days_____ More than half the days_____ Nearly every day_____

7. Feeling afraid as if something awful might happen?

Not at all_____ Several days_____ More than half the days_____ Nearly every day_____