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New Patient Paperwork

Demographics

First Name: _____

Middle Name: _____

Last Name(s): _____

Date of Birth (MM/DD/YYYY): _____

Preferred Language: _____

Social Security Number (SSN): _____

Home Address: _____

Phone Number: _____

Email Address: _____

Sex Assigned at Birth:

- ☐ Male
- ☐ Female

Gender identity:

- ☐ Male
- ☐ Female
- ☐ Transgender Male/Trans Man/Female-to-Male
- ☐ Transgender Female/Trans Woman/Male-to-Female
- ☐ Genderqueer, neither exclusively Male nor Female
- ☐ Additional gender category or other (please specify): _____
- ☐ Prefer not to specify

Sexual orientation:

- ☐ Straight or heterosexual
- ☐ Lesbian, gay, or homosexual
- ☐ Bisexual
- ☐ Something else, please describe: _____
- ☐ Don't know
- ☐ Prefer not to specify

Pregnancy status:

- ☐ Pregnant
- ☐ Not Pregnant
- ☐ Possibly Pregnant

Date of last menstrual period (MM/DD/YYYY): _____
Presumed conception date (MM/DD/YYYY): _____
Estimated delivery date (MM/DD/YYYY): _____

Pregnancy intent:

- ☐ Want to become pregnant in the next year
- ☐ No desire to become pregnant in the next year
- ☐ Ambivalent about becoming pregnant in the next year
- ☐ Not sure about desire to become pregnant in the next year
- ☐ Not applicable

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Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other (please specify): _____
- ☐ Prefer not to specify

Ethnicity:

- ☐ Hispanic or Latino (please specify): _____
- ☐ Not Hispanic or Latino
- ☐ Prefer not to specify

Emergency Contact Information

First Name: _____

Middle Name: _____

Last Name(s): _____

Address: _____

Phone Number: _____

Relationship: _____

Do you want to designate a family member or other individual with whom the provider may discuss your medical condition? If yes, whom? I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the individual(s) listed below:

Full Name	Relationship to Patient	Contact Number

Consulting Provider List (please list all current patient providers who regularly provide medical care)

Provider Name	Specialty	Address	Office Phone

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Preferred Pharmacy

Name: _____

Address: _____

Phone Number: _____

Medical Review

Allergies (please list all medication/drug, food, and environmental allergies)

Allergen	Onset Date	Reaction

Current Medication List (please list all current prescriptions, over-the-counter (OTC) drugs, and supplements)

Medication Name (specify dose form: Tablet, Capsule, Powder, etc.)	Dosage	Route	Frequency	Prescriber, if any

Route options include: oral, which is when a person swallows a drug / intraocular, or into the eye / intraotic, or into the ear/ nasal, or through the nose / sublingual, or under the tongue / buccal, between the gums and the mouth cheek / inhalation or nebulization, or inhaled through the respiratory system / enteral, which is when a person receives the drug directly into their digestive tract / rectal, or through the rectum / vaginal, or through the vagina / transdermal, or through the skin / subcutaneous, or under the skin / intramuscular, or via an injection into a muscle / intravenous, or into a vein / intra-arterial, or into an artery / intraosseous, or into the bone marrow

Past Medical History

- ☐ Alcohol Abuse
- ☐ Drug Abuse/ Substance Abuse
- ☐ Alzheimer's Disease and Related Dementia
- ☐ Heart Failure
- ☐ Arthritis (Osteoarthritis and/or Rheumatoid)
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Asthma
- ☐ HIV/AIDS
- ☐ Atrial Fibrillation
- ☐ Hyperlipidemia (High cholesterol)
- ☐ Autism Spectrum Disorders
- ☐ Hypertension (High blood pressure)
- ☐ Cancer (please specify): _____
- ☐ Ischemic Heart Disease
- ☐ Chronic Kidney Disease
- ☐ Osteoporosis
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Schizophrenia and/or Other Psychotic Disorders
- ☐ Depression
- ☐ Stroke
- ☐ Diabetes
- ☐ Other (please specify): _____ _____

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Surgical/Hospitalization History

Procedure/Reason for Hospitalization	Date of Procedure/Hospitalization	Hospital Name	Complications

Family Medical History

Relationship	Medical Condition	Age of Onset	Current Age	Age at Death and Cause of Death

Please include information about your children, your brothers and sisters, mother, (mother's side: aunts, uncles, grandparents), father, (father's side: aunts, uncles, grandparent)

Preventive Screenings (please bring in copies of results if available)

When was your last Ultrasound Abdominal Aorta? _____ ☐ Never

When was your last Low-Dose CT Thorax Without Contrast? _____ ☐ Never

When was your last Bone Density (DEXA) Scan? _____ ☐ Never

When was your last Colonoscopy/CT Colonography/FIT - DNA Lab Test (Cologuard)/Flexible Sigmoidoscopy/FOBT Lab Test? (please specify the colon screening test you had done) _____ ☐ Never

When was your last STI screening? _____ ☐ Never

Female-specific | When was your last Mammogram Screening? _____ ☐ Never/Does not apply

Female-specific | When was your last Papanicolaou (Pap) test? _____ ☐ Never/Does not apply

Female-specific | When was your last High-risk Human Papillomavirus (hrHPV) test? _____
☐ Never/Does not apply

Male-specific | When was your last Prostate Specific Antigen (PSA) test? _____ ☐ Never/Does not apply

Diabetes-specific | When was your last Diabetic Retinal Eye Exam to screen for diabetic retinopathy? _____
☐ Never/Does not apply

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Chief Complaint:

Main concern(s) for today's visit:

_____

_____

Pain Screening (over the past 7 days):

Pain location(s):

_____

_____

Intensity: On a scale of 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine, how does it hurt?

Present pain ____/10 Worst pain ____/10 Best pain ____/10

Is the pain constant?

- ☐ Yes
- ☐ No

Type of pain?

- ☐ Sharp: Sudden, intense.
- ☐ Dull/Aching: Persistent, deep, less intense.
- ☐ Burning/Hot/Searing: Intense.
- ☐ Stabbing/Piercing/Shooting: Intense, localized or radiating along a path.
- ☐ Throbbing/Pulsating: Rhythmic.
- ☐ Cramping/Tightness/Squeezing: Pressure-like.
- ☐ Tingling/Prickly: Pins and needles.
- ☐ Gnawing: Persistent, nagging.
- ☐ Itching: Maddening sensation.
- ☐ Other (specify): _____

Onset, duration and variations:

_____

_____

What relieves the pain?

_____

_____

Patient-provided Review of Systems: (select all that apply over the past 7 days)

Constitutional (General)

- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Unexplained weight loss or gain
- ☐ Night sweats

HEENT (Head, Eyes, Ears, Nose, Throat)

- ☐ Headaches
- ☐ Dizziness
- ☐ Head injury
- ☐ Vision changes (blurry, double)
- ☐ Eye pain
- ☐ Eye redness
- ☐ Hearing loss
- ☐ Ringing in ears (tinnitus)
- ☐ Nasal/sinus congestion
- ☐ Nasal/sinus discharge
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ Trouble swallowing (dysphagia)
- ☐ Mouth sores

Respiratory

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Chest pain with breathing
- ☐ Sputum production (phlegm)

Cardiovascular

- ☐ Chest pain
- ☐ Chest pressure
- ☐ Chest tightness
- ☐ Palpitations (racing heart)
- ☐ Irregular heartbeat
- ☐ Swelling in legs (edema)
- ☐ Pain in legs when walking (claudication)

Gastrointestinal (GI)

- ☐ Abdominal pain

- [ ] Abdominal cramping
- [ ] Nausea
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Constipation
- [ ] Heartburn
- [ ] Indigestion
- [ ] Blood in stool
- [ ] Black stools
- [ ] Loss of appetite

Genitourinary (GU)

- [ ] Pain or burning with urination (dysuria)
- [ ] Frequent urination (frequency)
- [ ] Excessive thirst (polydipsia)
- [ ] Difficulty starting or controlling urine flow
- [ ] Blood in urine

Neurological

- [ ] Headaches
- [ ] Migraines
- [ ] Numbness
- [ ] Tingling
- [ ] Weakness in arms or legs
- [ ] Seizures
- [ ] Tremors
- [ ] Difficulty with memory or concentration

Psychiatric

- [ ] Anxiety
- [ ] Depression
- [ ] Mood changes
- [ ] Sleep disturbances
- [ ] Thoughts of harming yourself or others

Integumentary (Skin)

- [ ] Rashes
- [ ] Itching
- [ ] Hives
- [ ] Skin lesions
- [ ] Moles changing
- [ ] Dry skin
- [ ] Hair loss
- [ ] Nail changes

Musculoskeletal (MSK)

- [ ] Back pain
- [ ] Neck pain
- [ ] Joint pain
- [ ] Joint swelling or stiffness
- [ ] Muscle cramps or weakness

Hematologic/Lymphatic (Blood/Lymph Nodes)

- [ ] Easy bruising or bleeding
- [ ] Swollen lymph nodes
- [ ] History of blood clots

Endocrine (Hormonal)

- [ ] Heat or cold intolerance
- [ ] Excessive thirst or hunger
- [ ] Changes in hair or skin

Immunologic/Allergies

- [ ] Food, drug, or seasonal allergies
- [ ] History of frequent infections

Advanced Care Planning

Have you completed any of the following documents? (please bring in a copy if available)

- [ ] Durable Power of Attorney for Health Care (DPAHC)
- [ ] Living Will
- [ ] Combined Advance Directive
- [ ] POLST (Physician Orders for Life-Sustaining Treatment)
- [ ] Identified a Surrogate Decision-Maker (informally or formally) (please include surrogate name):

  _____
- [ ] None of the above

Health Risk Assessment

In general, how would you describe your health?

- [ ] Excellent
- [ ] Very good
- [ ] Good
- [ ] Fair
- [ ] Poor

Vision Screening

1. Do you require prescription glasses to see?

- [ ] Yes
- [ ] No

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Adult Vision Risk Assessment:

	Yes	No
Do you have blood relatives with glaucoma?	1	0
Has a doctor treated you for or said you have glaucoma?	1	0
Have you ever had an eye injury or eye surgery?	1	0
Have you noticed a change in your vision over the last 12 months?	1	0
Do you have persistent pain in or around the eye?	1	0
Are you black, Hispanic or Latino, and over age 40?	1	0
Are you over age 65?	1	0
Do you have diabetes?	1	0
If you have diabetes, was your last dilated eye exam more than a year ago?	1	0

Hearing Screening

1. Do you require/use hearing aids?

☐ Yes ☐ No

ASHA Self-Test for Hearing Loss:

	Yes	No
Do you have a problem hearing over the telephone?	1	0
Do you hear better in one ear than the other when you are on the phone?	1	0
Do you have trouble understanding when two or more people talk at the same time?	1	0
Do people complain that you turn the TV volume up too high?	1	0
Do you have to strain to understand what people say?	1	0
Do you have trouble hearing in a noisy place?	1	0
Do you have trouble hearing in restaurants?	1	0
Do you have dizziness, pain, or ringing in your ears?	1	0
Do you ask people to repeat what they said?	1	0
Do family members or coworkers tell you that you are not hearing what they say?	1	0
Do many people you talk to seem to mumble or not speak clearly?	1	0
Do you have trouble understanding women and children?	1	0
Do people get annoyed because you don’t understand what they say?	1	0

Mental Health Screening:

Personal Health Questionnaire-9 (PHQ-9):

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Over the last 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
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

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

Generalized Anxiety Disorder 2-item (GAD-2):

Over the last 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 nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3

Perceived Stress Scale 4 (PSS-4):

Over the last month, how often have you been bothered by any of the following problems?	**Never**	**Almost Never**	**Sometimes**	**Fairly Often**	**Very Often**
In the last month, how often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
In the last month, how often have you felt confident about your ability to handle your personal problems?	4	3	2	1	0
In the last month, how often have you felt that things were going your way?	4	3	2	1	0
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

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Social/Emotional Support Screening:

1. How often do you get the social and emotional support you need?

☐ Always ☐ Sometimes ☐ Never
☐ Usually ☐ Rarely

Sleep Screening:

1. On average, how many hours of sleep do you usually get each night?
____ hours

2. Do you snore or has anyone told you that you snore?

☐ Yes ☐ No

3. In the past 7 days, how often have you felt sleepy during the daytime?

☐ Always ☐ Sometimes ☐ Never
☐ Usually ☐ Rarely

Epworth Sleepiness Scale (ESS):

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.	**Would never nod off**	**Slight chance of nodding off**	**Moderate chance of nodding off**	**High chance of nodding off**
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive, in a public place (e.g., in a meeting, theater, or dinner event)	0	1	2	3
As a passenger in a car for an hour or more without stopping for a break	0	1	2	3
Lying down to rest when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a meal without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic or at a light	0	1	2	3

AD8 Dementia Screening Interview:

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	**YES, A change**	**NO, No change**	**N/A, Don't know**
Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)	1	0	0
Less interest in hobbies/activities	1	0	0
Repeats the same things over and over (questions, stories, or statements)	1	0	0
Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)	1	0	0

Forgets correct month or year	1	0	0
Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)	1	0	0
Trouble remembering appointments	1	0	0
Daily problems with thinking and/or memory	1	0	0

Substance Use and Abuse Screening:

1. Have you ever used tobacco products?

☐ Never used *(skip to next section)* ☐ Former user *(answer the following)* ☐ Current user *(answer the following)*

Tobacco products used?

☐ Cigarettes
☐ Cigars
☐ E-cigarettes / Vape
☐ Smokeless tobacco products (including dip, snuff, snus, chewing tobacco, and nicotine pouches/dissolvables)
☐ Hookah / Pipes
☐ Bidis / Kreteks (hand-rolled cigarettes)

Year you started using tobacco products: _____
Year you quit using tobacco products: _____ ☐ does not apply (current user)

Extent of consumption?

☐ Light use: ≤ 10 cigarettes, 1 large cigar, 0.2 ml (100-150 puffs) of e-cigarette, or 2-3 average dips/pinches of smokeless tobacco products each day
☐ Moderate use: 10-20 cigarettes, 1-2 large cigars, 0.2 ml (100-150 puffs) - 0.4 ml (200-300 puffs) of e-cigarette, or 2-6 average dips/pinches of smokeless tobacco products each day
☐ Heavy use: > 20 cigarettes, 2 large cigars, 0.4 ml (200-300 puffs) of e-cigarette, or 4-6 average dips/pinches of smokeless tobacco products each day

Alcohol Use Disorders Identification Test (AUDIT-C):

One standard drink is equal to the following:

	0 pts	1 pt	2 pts	3 pts	4 pts
How often did you have a drink containing alcohol in the past year?	Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week
How many drinks did you have on a typical day when you were drinking in the past year?	0, 1, or 2	3 or 4	5 or 6	7 to 9	10 or more
How often did you have six or more drinks on one occasion in the past year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Alcohol, Smoking and Substance Involvement Screening (ASSIST-Lite):

In the past 3 months…	Yes	No
1. Did you smoke a cigarette, cigar, e-cigarette or used smokeless tobacco products that are chewed, sucked or sniffed?	1	0
1a. Did you usually smoke more than 10 cigarettes, 1 large cigar, 0.2 ml (100-150 puffs) of e-cigarette, or 2-3 average dips/pinches of smokeless tobacco products each day?	1	0
1b. Did you usually smoke and/or consume tobacco within 30 minutes after waking?	1	0
2. Did you have a drink containing alcohol?	1	0
2a. On any occasion, did you drink more than 4 standard drinks of alcohol?	1	0
2b. Have you tried and failed to control, cut down or stop drinking?	1	0
2c. Has anyone expressed concern about your drinking?	1	0
3. Did you use cannabis?	1	0
3a. Have you had a strong desire or urge to use cannabis at least once a week or more often?	1	0
3b. Has anyone expressed concern about your use of cannabis?	1	0
4. Did you use an amphetamine-type stimulant, or cocaine, or a stimulant medication not as prescribed?	1	0
4a. Did you use a stimulant at least once each week or more often?	1	0
4b. Has anyone expressed concern about your use of a stimulant?	1	0
5. Did you use a sedative or sleeping medication not as prescribed?	1	0
5a. Have you had a strong desire or urge to use a sedative or sleeping medication at least once a week or more?	1	0
5b. Has anyone expressed concern about your use of a sedative or sleeping medication?	1	0
6. Did you use a street opioid (e.g. heroin) or an opioid-containing medication not as prescribed?	1	0
6a. Have you tried and failed to control, cut down or stop using an opioid?	1	0
6b. Has anyone expressed concern about your use of an opioid?	1	0
7. Did you use any other psychoactive substances?	Yes	No
If yes, what did you take?		

Social Needs Screening:

Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening:

Living Situation

What is your living situation today?

- ☐ I have a steady place to live
- ☐ I have a place to live today, but I am worried about losing it in the future

☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park

Think about the place you live. Do you have problems with any of the following?

☐ Pests such as bugs, ants, or mice
☐ Mold
☐ Lead paint or pipes
☐ Lack of heat
☐ Oven or stove not working
☐ Smoke detectors missing or not working
☐ Water leaks
☐ None of these

Food

Within the past 12 months, you worried that your food would run out before you got money to buy more.

☐ Often true ☐ Sometimes true ☐ Never true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

☐ Often true ☐ Sometimes true ☐ Never true

Transportation

In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

☐ Yes ☐ No

Utilities

In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

☐ Yes ☐ No ☐ Already shut off

Safety

Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.	**Never**	**Rarely**	**Sometimes**	**Fairly Often**	**Frequently**
How often does anyone, including family and friends, physically hurt you?	1	2	3	4	5
How often does anyone, including family and friends, insult or talk down to you?	1	2	3	4	5
How often does anyone, including family and friends, threaten you with harm?	1	2	3	4	5
How often does anyone, including family and friends, scream or curse at you?	1	2	3	4	5

Functional Assessment Screening:

1. Do you require any of the following assistive devices to ambulate (move around)?

☐ Cane
☐ Crutches
☐ Walker
☐ Wheelchair
☐ Scooter
☐ Prosthetic devices (Custom-fitted artificial limbs)
☐ Orthotic devices (Braces that stabilize or immobilize limb segments)
☐ None, fully independent for ambulation

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Lawton - Brody Instrumental Activities of Daily Living (IADL) Scale:

A. Ability to Use Telephone	**Pts**	**E. Laundry**	**Pts**
1. Operates telephone on own initiative-looks up and dials numbers, etc.	1	1. Does personal laundry completely	1
2. Dials a few well-known numbers	1	2. Launders small items-rinses stockings, etc.	1
3. Answers telephone but does not dial	1	3. All laundry must be done by others	0
4. Does not use telephone at all	0		
B. Shopping	**Pts**	**F. Mode of Transportation**	**Pts**
1. Takes care of all shopping needs independently	1	1. Travels independently on public transportation or drives own car	1
2. Shops independently for small purchases	0	2. Arranges own travel via taxi, but does not otherwise use public transportation	1
3. Needs to be accompanied on any shopping trip	0	3. Travels on public transportation when accompanied by another	1
4. Completely unable to shop	0	4. Travel limited to taxi or automobile with assistance of another	0
		5. Does not travel at all	0
C. Food Preparation	**Pts**	**G. Responsibility for Own Medications**	**Pts**
1. Plans, prepares and serves adequate meals independently	1	1. Is responsible for taking medication in correct dosages at correct time	1
2. Prepares adequate meals if supplied with ingredients	0	2. Takes responsibility if medication is prepared in advance in separate dosage	0
3. Heats, serves and prepares meals, or prepares meals but does not maintain adequate diet	0	3. Is not capable of dispensing own medication	0
4. Needs to have meals prepared and served	0		
D. Housekeeping	**Pts**	**H. Ability to Handle Finances**	**Pts**
1. Maintains house alone or with occasional assistance (e.g. "heavy work domestic help")	1	1. Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to bank), collects and keeps track of income	1
2. Performs light daily tasks such as dish washing, bed making	1	2. Manages day-to-day purchases, but needs help with banking, major purchases, etc.	1
3. Performs light daily tasks but cannot maintain acceptable level of cleanliness	1	3. Incapable of handling money	0
4. Needs help with all home maintenance task	1		
5. Does not participate in any housekeeping tasks	0		

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Katz Index of Independence in Activities of Daily Living (ADL):

Activities Points (1 or 0)	**Independence** (1 point) **NO** supervision direction or personal assistance	**Dependence** (0 points) **WITH** supervision, direction, personal assistance or total care
BATHING Points: _____	**(1 POINT)** Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	**(0 POINTS)** Need help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
DRESSING Points: _____	**(1 POINT)** Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	**(0 POINTS)** Needs help with dressing self or needs to be completely dressed.
TOILETING Points: _____	**(1 POINT)** Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	**(0 POINTS)** Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING Points: _____	**(1 POINT)** Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable.	**(0 POINTS)** Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: _____	**(1 POINT)** Exercises complete self control over urination and defecation.	**(0 POINTS)** Is partially or totally incontinent of bowel or bladder
FEEDING Points: _____	**(1 POINT)** Gets food from plate into mouth without help. Preparation of food may be done by another person.	**(0 POINTS)** Needs partial or total help with feeding or requires parenteral feeding.

Home Safety Screening

Fall Risk	**Yes**	**No**
Do you feel unsteady when standing or walking?	1	0
Are you worried about falling?	1	0
Have you fallen in the past year?	1	0
If you have fallen in the past year, how many times? Were you injured?		
Home Hazards	**Yes**	**No**
Are there loose rugs or mats in your home?	1	0
Are walkways cluttered (cords, furniture, objects)?	1	0
Does your home have poor lighting in some areas?	1	0
Do you have night lights?	1	0
Bathroom Safety	**Yes**	**No**
Do you have grab bars in the shower/bath and/or near the toilet?	1	0
Do you have non-slip mats in the tub/shower?	1	0
Do you have difficulty getting in/out of the tub and/or getting on/off the toilet?	1	0

Stairs	**Yes**	**No**
Do stairs in your home have handrails?	1	0
Are the stairs poorly lit?	1	0
Do you have difficulty using the stairs?	1	0
Mobility	**Yes**	**No**
Do you use a cane, walker, or wheelchair?	1	0
Do you have trouble getting up from chairs and/or bed?	1	0
Safety	**Yes**	**No**
Do you wear loose or unsafe footwear at home?	1	0
Can you easily call for help in an emergency?	1	0

Nutrition Screening

Malnutrition Screening Tool (MST):

1. Have you recently lost weight without trying?

☐ No [0] ☐ Yes [2]

If yes, how much weight have you lost?

☐ 2-13 lb (1-6 kg) [1] ☐ 24-33 lb (10-15 kg) [3] ☐ Unsure [2]
☐ 14-23 lb (6-10 kg) [2] ☐ 34+ lb (15+ kg) [4]

2. Have you been eating poorly because of a decreased appetite?

☐ No [0] ☐ Yes [1]

Starting The Conversation: Diet Instrument:

Over the past few months:	**0 pts**	**1 pts**	**2 pts**
How many times a week did you eat fast food meals or snacks?	Less than 1 time	1-3 times	4 or more times
How many servings of fruit did you eat each day?	5 or more	3-4	2 or less
How many servings of vegetables did you eat each day?	5 or more	3-4	2 or less
How many regular sodas or glasses of sweet tea did you drink each day?	Less than 1	1-2	3 or more
How many times a week did you eat beans (like pinto or black beans), chicken, or fish?	3 or more times	1-2 times	Less than 1 time
How many times a week did you eat regular snack chips or crackers (not low-fat)?	1 time or less	2-3 times	4 or more times
How many times a week did you eat desserts and other sweets (not the low-fat kind)?	1 time or less	2-3 times	4 or more times
How much margarine, butter, or meat fat do you use to season vegetables or put on potatoes, bread, or corn?	Very little	Some	A lot

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Physical Activity Screening

Rapid Assessment of Physical Activity (RAPA):

Examples of physical activity intensity levels:

Light activities
- Your heart beats slightly faster than normal
- You can talk and sing
- Examples: Walking Leisurely, Stretching, Vacuuming, or Light Yard Work

Moderate activities
- Your heart beats faster than normal
- You can talk but not sing
- Examples: Fast Walking, Aerobics Class, Strength Training, Swimming Gently

Vigorous activities
- Your heart rate increases a lot
- You can't talk or your talking is broken up by large breaths
- Examples: Stair Machine, Jogging or Running, Tennis, Racquetball, Pickleball or Badminton

How physically active are you?	**Does this accurately describe you?**	
RAPA 1: Aerobic	**Yes**	**No**
I rarely or never do any physical activities.	1	0
I do some light or moderate physical activities, but not every week.	1	0
I do some light physical activity every week.	1	0
I do moderate physical activities every week, but less than 30 minutes a day or 5 days a week.	1	0
I do vigorous physical activities every week, but less than 20 minutes a day or 3 days a week.	1	0
I do 30 minutes or more a day of moderate physical activities, 5 or more days a week.	1	0
I do 20 minutes or more a day of vigorous physical activities, 3 or more days a week.	1	0
RAPA 2: Strength & Flexibility	**Yes**	**No**
I do activities to increase muscle strength, such as lifting weights or calisthenics, once a week or more.	1	0
I do activities to improve flexibility, such as stretching or yoga, once a week or more.	1	0

Seat Belt Use

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

☐ Yes ☐ No

Sexual Risk Screening

Are you sexually active?

☐ Yes ☐ No

In the past 12 months, have you been diagnosed with any STIs?

☐ Yes ☐ No

Sexual Risk Behavior Scale (SRBS)

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	Never	Rarely	Sometimes	Often	Very Often
How often have you had vaginal sex without a condom?	0	1	2	3	4
How often have you had anal sex without a condom?	0	1	2	3	4
How often have you performed oral sex without protection (condom or dental dam)?	0	1	2	3	4
How often have you had sex while under the influence of alcohol (i.e. drunk)?	0	1	2	3	4
How often have you had sex while under the influence of drugs or substances?	0	1	2	3	4
How often have you had sex without a condom with someone you have just met?	0	1	2	3	4

This concludes the New Patient Paperwork. Please ensure you have answered all questions as applicable. Please ensure that you bring in your legal form of ID, physical insurance card, legal documents (e.g. Durable Power of Attorney for Health Care, Living Will, Combined Advance Directive, Physician Orders for Life-Sustaining Treatment, preventive screening reports, and any other pertinent records). Please sign the acknowledgement below.

I hereby certify that I have answered all questions truthfully and wholly to the best of my abilities.

_____

Patient Name

_____

Patient Signature

_____

Date of Signature

_____

If Patient unable to sign, Name of Patient's Legal Guardian/Personal Representative

_____

Legal Guardian's/Personal Representative's Signature

_____

Description of Authority to Act for the Individual