utica park clinic
Get Healthy. Stay Healthy.

NAME: _____

DOB: _____

Health and Wellness Assessment

GENERAL WELLNESS

In general, would you say your health is?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

In the past 12 months, have you stayed overnight as a patient in a hospital?

- ☐ None
- ☐ Once
- ☐ Two or three times
- ☐ Four or more times

In the last 12 months, how many times did you visit a physician or clinic?

- ☐ None
- ☐ Once
- ☐ Two or three times
- ☐ Four to six times
- ☐ Seven or more times

Do you feel you have adequate social/emotional support?

☐ Yes ☐ No

Do you experience a high stress level or difficulty coping?

☐ Yes ☐ No

LIFESTYLE

Do you usually eat a diet that has four servings of fruit and vegetables, includes whole grain and fiber and avoids other than occasional servings of high fat foods?

☐ Yes ☐ No

Do you usually exercise at least 30 minutes or more, four days a week?

☐ Yes ☐ No

In the past seven days, how much pain have you felt?

- ☐ None
- ☐ Some
- ☐ A lot

How would you describe the condition of your mouth and teeth (including false teeth or dentures)?

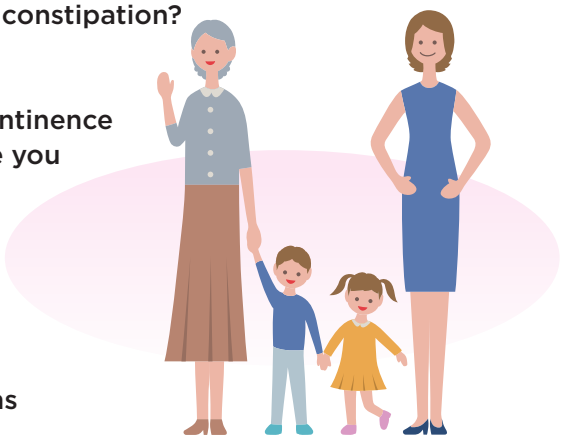
- ☐ Excellent
- ☐ Good
- ☐ Poor

In the past seven days, have you had any trouble falling or staying asleep?

☐ Yes ☐ No

In the past seven days, have you had problems with constipation?

☐ Yes ☐ No



Many people experience problems with urinary incontinence or the leakage of urine. In the past six months, have you been affected by the accidental leakage urine?

☐ Yes ☐ No

Do you have any problems with your hearing?

☐ Yes ☐ No

Do you or any of your family members have concerns about your memory?

☐ Yes ☐ No

In a typical week, how much alcohol do you drink?

- ☐ None
- ☐ Two drinks per day or less
- ☐ More than two drinks per day

PERSONAL SAFETY

Do you know where to locate and properly use a first aid kit and fire extinguisher in case of emergency?

☐ Yes ☐ No

Do you wear sunscreen?

☐ Yes ☐ No

Does your home have rugs in the hallway?

☐ Yes ☐ No

Does your home have grab bars in the bathroom?

☐ Yes ☐ No

Does your home have handrails on the stairs?

☐ Yes ☐ No

Does your home have good lighting?

☐ Yes ☐ No

Do you have smoke detectors in your home?

☐ Yes ☐ No

Do you have Carbon Monoxide detectors in your home?

☐ Yes ☐ No

Has your home been positive for Radon?

☐ Yes ☐ No

Is the heat in your home adequate?

☐ Yes ☐ No

Do you feel safe at home?

☐ Yes ☐ No

INDEPENDENCE

In the past seven days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking or using the toilet?

☐ Yes ☐ No

In the past seven days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications?

☐ Yes ☐ No

Have you fallen in the last year?

☐ Two or more falls in the last year or fall with injury in the last year
☐ No falls in the last year, or one fall with no injury in the last year

MENTAL HEALTH

Over the last two weeks, how often have you felt little interest or pleasure in doing things?

☐ Not at all
☐ Several days
☐ More than half of the days
☐ Nearly every day

Over the last two weeks, how often have you felt down, depressed or hopeless?

☐ Not at all
☐ Several days
☐ More than half of the days
☐ Nearly every day

PLANNING AHEAD

Please select all of the below that you have completed:

☐ Power of Attorney
☐ Living Will
☐ Advanced Directive

Please bring these documents with you to your appointment.

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Please list the names of your doctors, medical providers, nurses and medical suppliers that you see outside of Utica Park Clinic.

NAME	SPECIALTY	SERVICES YOU RECEIVE

Please provide the date and location for the last time the following tests were performed.

TEST	DATE	LOCATION
Colonoscopy		
Mammogram		
Pap Smear		
Bone Density		
Eye Exam		

Please provide the date and location for the last time the following immunizations were given.

IMMUNIZATION	DATE	LOCATION
Flu		
Pneumonia		
Shingles		

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