Name: _____ **Date:** _____

Pain Screening

Circle one:

0 1 2 3 4 5 6 7 8 9 10

Comments: _____

Fall Screening

How many falls has the patient had in the last year? _____

Number of falls with injury in the last year: _____

Comments: _____

Depression Screening

Over the past 2 weeks, how often have you been bothered by any of the following problems?

(0 =Not at all, 1 =Several days, 2 =More than half the days, 3 =Nearly every day)

1. Little interest or pleasure in doing things
   0 1 2 3
2. Feeling down, depressed, or hopeless
   0 1 2 3
3. Trouble falling asleep or staying asleep, or sleeping too much
   0 1 2 3
4. Feeling tired or having little energy
   0 1 2 3
5. Poor appetite or overeating
   0 1 2 3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down
   0 1 2 3
7. Trouble concentrating on things such as reading the newspaper or watching television
   0 1 2 3
8. Moving or speaking so slowly that other people 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
9. Thoughts that you would be better off dead or of hurting yourself in some way
   0 1 2 3

Total point score _____

Comments: _____

Name: _____ Date: _____

If you have had any of these problems, how difficult have they made it for you to do your work, take care of things at home or get along with other people? **(Select one option below)**

___ Not difficult ___ Somewhat difficult ___ Very difficult ___ Extremely difficult

Alcohol Use Screening

1. How often do you have a drink containing alcohol? **(Select one option below)**
   Never | Monthly or Less | 2-4 times a month | 4 or more times a week | Declined

2. How many standard drinks (12 oz. beer, 5 oz. wine, 1.5 oz. shot, 8-9 oz. malt liquor) containing alcohol do you have on a typical day?
   1 or 2 | 3 or 4 | 5 or 6 | 7 or 9 | 10 or more | Declined

3. How often do you have 6 or more drinks on 1 occasion?
   Never | Less than monthly | Monthly | Weekly | Daily or almost daily | Declined

Medication Adherence

1. Do you sometimes forget to take your pills?
   No Yes
2. People sometimes miss taking their medications for reasons other than forgetting. Thinking over the past two weeks, were there any days when you did not take your medicine?
   No Yes
3. Have you ever cut back or stopped taking your medicine without telling your doctor because you felt worse when you took it?
   No Yes
4. When you travel or leave home, do you sometimes forget to bring along your medicine?
   No Yes
5. Did you take all your medicine yesterday?
   No Yes
6. When you feel like your symptoms are under control, do you sometimes stop taking your medicine?
   No Yes
7. Taking medicine every day is a real inconvenience for some people. Do you ever feel hassled about sticking to your treatment plan?
   No Yes
8. How often do you have difficulty remembering to take all your medicine?
   Never/Rarely | Once in a while | Sometimes | Usually | All the time