Family Medicine Associates of Conroe
Treating Your Family Like Ours

YOUR NAME: _____

DATE OF WELLNESS VISIT: _____

Please bring this HEALTH RISK ASSESSMENT to your upcoming WELLNESS VISIT in our office. In addition, please bring the following:

- **A list of your current medications & supplements.**
- **A list of any specialists you may see.**
- **A list of the immunizations you know you've had.**

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1. What is your age? _____

2. Are you a male or female?
   ◯ Male ◯ Female

3. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted & blue?
   ◯ Not at all
   ◯ Slightly
   ◯ Moderately
   ◯ Quite a bit
   ◯ Extremely

4. During the past four weeks, has your physical & emotional health limited your social activities with family, friends, neighbors, or groups?
   ◯ Not at all
   ◯ Slightly
   ◯ Moderately
   ◯ Quite a bit
   ◯ Extremely

5. During the past 4 weeks, how much bodily pain have you generally had?
   ◯ No pain
   ◯ Mild pain
   ◯ Moderate pain
   ◯ Severe pain

6. During the past 4 weeks, was someone available to help you if you needed & wanted help? For example, if you felt very nervous, lonely, or blue; got sick & had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help taking care of yourself?
   ◯ Yes, as much as I wanted.
   ◯ Yes, quite a bit.
   ◯ Yes, some.
   ◯ No, not at all.

7. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
   ◯ Very heavy activity
   ◯ Heavy activity
   ◯ Moderate activity
   ◯ Light activity
   ◯ Very light activity or none

8. Can you get places without help? For example, can you travel alone on buses or taxis, drive your own car, or have others who are willing to transport you?
   ◯ Yes ◯ No

9. Can you go shopping for groceries or clothes without someone's help?
   ◯ Yes ◯ No

10. Can you prepare your own meals?
    ◯ Yes ◯ No

11. Can you do your housework without help?
    ◯ Yes ◯ No

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?
    ◯ Yes ◯ No

13. Can you handle your own money without help?
    ◯ Yes ◯ No

14. During the past 4 weeks, how would you rate your health in general?
    ◯ Excellent
    ◯ Very good or good
    ◯ Fair or poor

15. How have things been going for you during the past 4 weeks?

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◯ Very well; could hardly be better
◯ Pretty well
◯ Good & bad parts about equal
◯ Pretty bad
◯ Very bad; could hardly be any worse

16. Are you having difficulties driving your car?
◯ Yes ◯ No

17. Do you always fasten your seatbelt when you are in a car?
◯ Yes ◯ No

18. How often during the past 4 weeks have you been bothered by any of the following problems?

	Never	Sometimes	Always
Falling			
Dizzy when standing up			
Sexual problems			
Trouble eating well			
Teeth or denture problems			
Problems using the phone			
Tiredness or fatigue			

19. Have you fallen 2 or more times in the past year?
◯ Yes ◯ No

20. Are you afraid of falling?
◯ Yes ◯ No

21. Are you a smoker?
◯ Yes ◯ No

22. During the past 4 weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?
◯ 10 or more drinks per week
◯ 6-9 drinks per week
◯ 2-5 drinks per week
◯ One drink or less per week
◯ No alcohol at all

23. Do you exercise for about 20 minutes 3 or more days a week?
◯ Yes, most of the time.
◯ Yes, some of the time.
◯ No, I usually don't exercise this much.

24. Have you been given any information to help you with the following:
a. Hazards in your house that might hurt you
◯ Yes ◯ No
b. Keeping track of your medications
◯ Yes ◯ No

25. 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.
◯ Poor

26. How confident are you that you can control & manage most of your health problems?
◯ Very confident.
◯ Somewhat confident.
◯ Not very confident.
◯ I dot not have any health problems.

27. What is your race? Check all that apply.
◯ White
◯ Black or African American
◯ Asian
◯ Native Hawaiian or Pacific Islander
◯ American Indian or Alaskan Native
◯ Hispanic or Latino origin or descent

Thank you very much for completing Health Risk Assessment! Please give the completed form to your doctor or nurse prior to your WELLNESS VISIT.

- **WELLNESS VISITS are designed to review your level of health and wellness & develop a plan to prevent health problems that may be within your control.**
- **WELLNESS VISITS include an assessment of your psychological & physical well-being. Please answer these questions and questionnaires as honestly as you can.**
- **If blood testing is requested as part of your WELLNESS VISIT, please report to the lab fasting (nothing to eat or drink after midnight) 5-7 days prior to your appointment to have your blood drawn.**
- **Please call & reschedule 24 hours prior to your wellness visit if there is a chance you may miss the appointment to avoid an unnecessary fee of $125 for missed appointments & late cancellations.**

Name:_____ Date:_____

PHQ-9

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	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 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 over eating	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 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
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

PHQ-9 Total Score ☐

Q6 CORE 10	I made plans to end my life in the last 2 weeks	YES	NO

GAD-7

Over the last 2 weeks, on how many days have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

GAD-7 Total Score ☐

AUDIT ALCOHOL SCREENING TOOL

UNIT GUIDE

1 unit is typically:

Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

The following drinks have more than one unit:

A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 175ml glass of wine (12%)

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence