AstranaCare

AWV Patient Intake:

PATIENT INFORMATION

Patient Name: _____ _____ _____
First Name M Last Name Suffix

Date of Birth: _____/_____/_____ **Sex:** ☐ Male ☐ Female ☐ Other: _____

Phone Number: _____- _____-_____

Address: _____ _____
Apt./Ste/Unit

_____ _____ _____
City State Zip Code

QUESTIONNAIRE

Pain Screening Tool:

1. On a scale of 1-10 with **10 being the worst pain imaginable**, what was your average pain level experienced? (Check One) ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

Depression Screening:

In the past 2 weeks have you felt little interest or pleasure in doing things?	YES ☐	NO ☐
During the past 2 weeks have you felt down, depressed or hopeless?	YES ☐	NO ☐

IF YOU ANSWERED YES TO EITHER OF THE 2 QUESTIONS ABOVE, PLEASE COMPLETE THE BELOW QUESTIONNAIRE.

Over the last 2 weeks have you experienced:	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, hopeless	☐	☐	☐	☐
Trouble falling asleep, staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself – or that you are a failure or let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things such as reading or watching TV	☐	☐	☐	☐
Moving or speaking slowly that other people have noticed or being fidgety or more restless	☐	☐	☐	☐
Thoughts you would be better off dead or thoughts of hurting yourself in some way.	☐	☐	☐	☐

TOTAL _____

General Health:

1. How would you rate your health? (Check One) Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐
2. How many days per week do you exercise? ___
3. Do you feel isolated from family and friends? (Check one) Yes ☐ No ☐
4. Are you currently sexually active? (Check one) Yes ☐ No ☐
   a. If so, are you experiencing any issues with sexual health? (Check one) Yes ☐ No ☐
5. Do you have any barriers to taking your medications? (Check one) Yes ☐ No ☐
6. Do you have issues with holding urine or stool? (Check one) Yes ☐ No ☐
7. Do you have advanced directives? (Check one) Yes ☐ No ☐

Hearing/Vision:

	YES	NO
Do you have trouble hearing the television or radio?	☐	☐
Do you strain to hear/understand conversations?	☐	☐
Do you have trouble with your vision?	☐	☐

Activities of Daily Living:

	YES	NO
Live alone?	☐	☐
Have trouble with shopping or buying groceries?	☐	☐
Have trouble bathing/showering?	☐	☐
Have trouble with light housework?	☐	☐
Have trouble preparing meals?	☐	☐
Have trouble managing finances?	☐	☐
Have trouble with transportation?	☐	☐

Balance/Memory:

	YES	NO
Do you have or have been told you have issues with your memory?	☐	☐
Do you have issues with balance or falls?	☐	☐
Have you had a fall in the past year **(2 points)**	☐	☐
Have you been advised to or currently use a cane/walker? **(2 points)**	☐	☐
Do you feel unsteady when walking?	☐	☐
Do you steady yourself by holding onto furniture?	☐	☐
Are you worried about falling?	☐	☐
Do you need to push with your hands to stand up from a chair?	☐	☐
Do you have trouble stepping up onto a curb?	☐	☐

	YES	NO
Do you have to rush to the toilet?	☐	☐
Do you have loss of sensation in your feet?	☐	☐
Do you take medication that make you feel light-headed or more tired than usual?	☐	☐
Do you take medication to sleep or improve mood?	☐	☐
Do you often feel sad or depressed?	☐	☐

TOTAL _____

Social Determinants of Health: Would you like help with any of the following? (Check All That Apply)

Food ☐	Dental Services ☐	Debt/Loan Repayment ☐
Housing ☐	Vision Services ☐	Legal Issues ☐
Transportation ☐	Public Benefits ☐	Employment ☐
Utilities ☐	Activities of Daily Living ☐	Other ☐
Medicines/Supplies ☐	Child Care ☐	

Social History:

1. What is your marital status? Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐
2. In the last 4 weeks how many alcoholic beverages have you consumed? _____

	YES	NO
Do you use any recreational or illicit drugs?	☐	☐
Do you use any form of tobacco or nicotine?	☐	☐
Do you have a chronic cough?	☐	☐
Are you experiencing shortness of breath?	☐	☐
Have you smoked more than 1 pack a day for more than 10 years?	☐	☐
Have you used supplemental oxygen in the last 6 months?	☐	☐

Preventative Checklist:

	I Need Y/N	Date Last Received MM/DD/YY	Results
Annual Exam	Yes ☐ No ☐		
Colorectal Cancer Screening (Check Test Type)			
☐ FOBT/FIT (annual stool test)	Yes ☐ No ☐		
☐ Cologuard (DNA stool test)	Yes ☐ No ☐		
☐ CT Colonography (CT scan)	Yes ☐ No ☐		
☐ Colonoscopy (with a Gastroenterologist)	Yes ☐ No ☐		

	I Need Y/N	Date Last Received MM/DD/YY	Results
Cardiovascular Screening (Blood Pressure, Cholesterol, lipids/fats)	Yes ☐ No ☐		
Diabetes Screening (A1c)	Yes ☐ No ☐		
Diabetic Eye Exam Location: _____	Yes ☐ No ☐		
Cervical/Vaginal Screening (Pap Smear)	Yes ☐ No ☐		
Breast Cancer Screening (Mammogram)	Yes ☐ No ☐		
Bone Mass Measurement (Bone Density)	Yes ☐ No ☐		
Flu Shot	Yes ☐ No ☐		
Hepatitis B Shot	Yes ☐ No ☐		
Pneumococcal Shot	Yes ☐ No ☐		
Shingrix	Yes ☐ No ☐		
RSV	Yes ☐ No ☐		
Covid Vaccine	Yes ☐ No ☐		
Other: _____	Yes ☐ No ☐		

Other Treating Providers:

Provider Name	Specialty