DATE: _______________ NAME: _______________________ Date Of Birth: _____________

MEDICARE HEALTH RISK ASSESSMENT
G0439/G0438/G0402 + MOD 25

GENERAL HEALTH	
1. How is your overall health?	▢ Excellent ▢ Good ▢ Fair ▢ Poor
2. Do you take all of your medications as prescribed?	▢ Yes ▢ Sometimes ▢ Almost Never ▢ No ▢ I don't take medication
3. How many times in the last six months have you been to the emergency room?	▢ 0 ▢ 1-2 ▢ 3-4 ▢ 5+
4. How many times in the last six months were you admitted to the hospital?	▢ 0 ▢ 1-2 ▢ 3-4 ▢ 5+
TOBACCO AND ALCOHOL USE	
1. Do you use any tobacco products?	▢ Yes ▢ No
2. If yes, are you interested in quitting tobacco use?	▢ Yes ▢ No
3. How many times in the past year have you had four or more alcoholic drinks in one day?	▢ 0 ▢ 1-2 ▢ 3-4 ▢ 5+
4. Are you interested in receiving help for any other type of substance abuse?	▢ Yes ▢ No

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SLEEP	
1. How many hours of sleep do you usually get?	▢ 0-3 ▢ 4-6 ▢ 7-10 ▢ 10+
2. Do you snore or has anyone told you that you snore?	▢ Yes ▢ No
3. In the past seven days how often have you felt sleepy during the day?	▢ Often ▢ Sometimes ▢ Almost Never ▢ Never
FUNCTIONAL STATUS ASSESSMENT	
4. Which of the following can you do on your own without help?	▢ Shop for groceries ▢ Make meals ▢ Drive/use public transportation ▢ Take medications ▢ Housework ▢ Use the telephone ▢ Handle finances ▢ None
ACTIVITIES OF DAILY LIVING	
1. Which is the following: can you do it on your own without help?	▢ Bathe ▢ Dress ▢ Eat ▢ Walk ▢ Transfer (In/Out of chairs, etc.) ▢ Use the restroom ▢ None
2. Many people experience leakage of urine called urinary incontinence. In the past six months have you experienced leaking or urine?	▢ Yes ▢ No

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FALL RISK ASSESSMENT		
1. I have fallen in the past year	▢ Yes (2)	▢ No (0)
2. I use or have been advised to use a cane or walker to get around safely	▢ Yes (2)	▢ No (0)
3. Sometimes I feel unsteady when I am walking	▢ Yes (1)	▢ No (0)
4. I steady myself by holding onto furniture when walking at home	▢ Yes (1)	▢ No (0)
5. I am worried about falling	▢ Yes (1)	▢ No (0)
6. I need to push with my hands to stand up from a chair	▢ Yes (1)	▢ No (0)
7. I have some trouble stepping up onto a curb	▢ Yes (1)	▢ No (0)
8. I often have to rush to the toilet	▢ Yes (1)	▢ No (0)
9. I have lost some feeling in my feet	▢ Yes (1)	▢ No (0)
10. I take medicine that sometimes make me feel light-headed or more tired than usual	▢ Yes (1)	▢ No (0)
11. I take medicine to help me sleep or improve my mood	▢ Yes (1)	▢ No (0)
12. I often feel sad or depressed	▢ Yes (1)	▢ No (0)
Total ___________ Add up the number of points for each yes. If you scored 4 or more points you may be at risk for falls		

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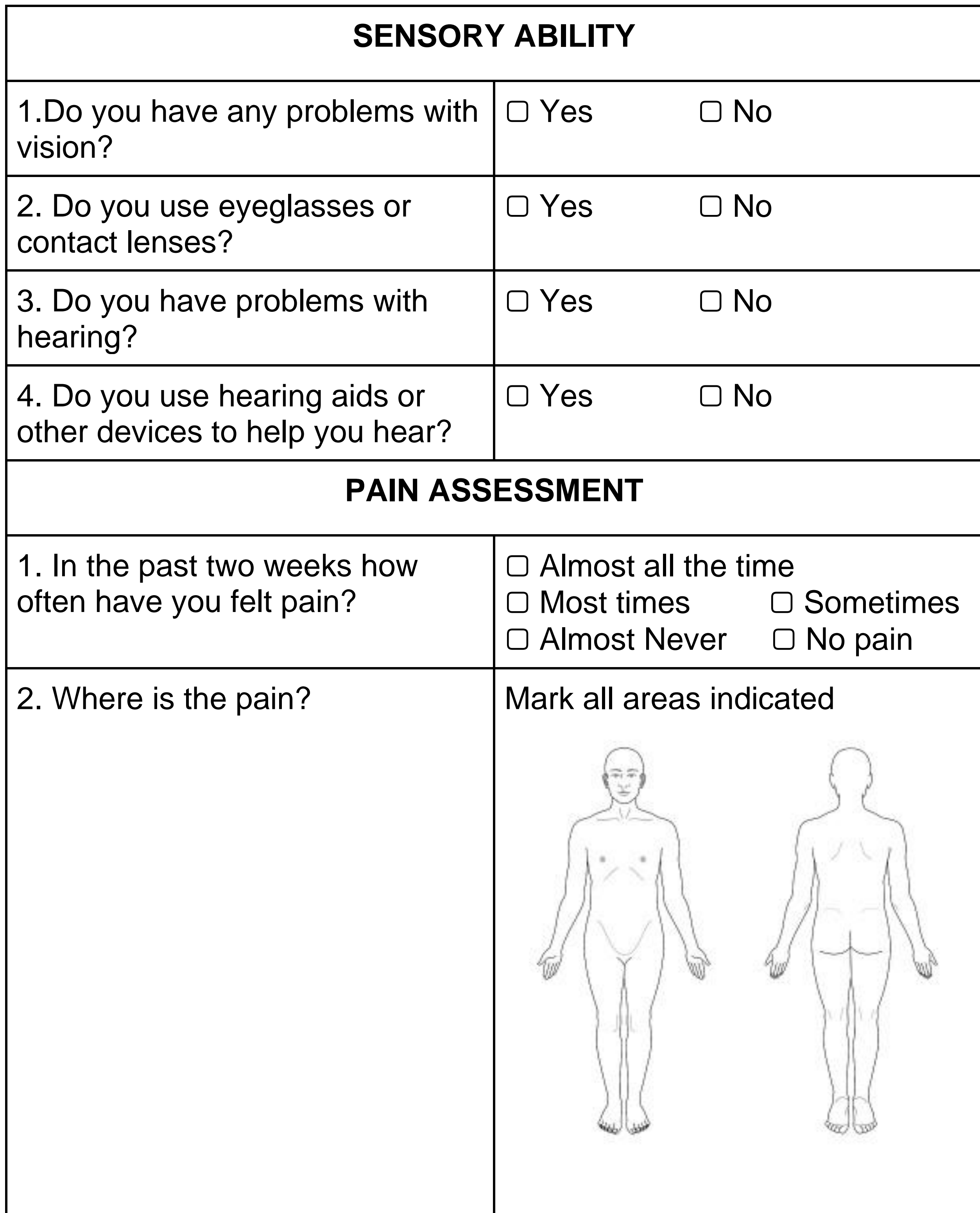

SENSORY ABILITY	
1.Do you have any problems with vision?	▢ Yes ▢ No
2. Do you use eyeglasses or contact lenses?	▢ Yes ▢ No
3. Do you have problems with hearing?	▢ Yes ▢ No
4. Do you use hearing aids or other devices to help you hear?	▢ Yes ▢ No
PAIN ASSESSMENT	
1. In the past two weeks how often have you felt pain?	▢ Almost all the time ▢ Most times ▢ Sometimes ▢ Almost Never ▢ No pain
2. Where is the pain?	Mark all areas indicated

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PAIN ASSESSMENT	
3. How do you treat the pain?	▢ Medication ▢ Rest ▢ Heat or Cold ▢ Therapy ▢ Other ▢ No treatment
4. Rate your pain on a scale of 0-10, with 0 being no pain and 10 being the worst pain.	Circle the number on the scale PAIN MEASUREMENT SCALE NO PAIN / MILD PAIN / MODERATE PAIN / SEVERE PAIN / VERY SEVERE PAIN / WORST PAIN IMAGINABLE 0 1 2 3 4 5 6 7 8 9 10 NO HURT / HURTS LITTLE BIT / HURTS LITTLE MORE / HURTS EVEN MORE / HURTS WHOLE LOT / HURTS WORST
HOME SAFETY	
1. What is your living situation?	▢ Alone ▢ With a friend or roommate ▢ With spouse or family member ▢ In a nursing home or assisted living facility ▢ I don't have a place to live ▢ Other
2. Does your home have working smoke alarms?	▢ Yes ▢ No
3. Is your home free from fall risk such as throw rugs or clutter on the floor?	▢ Yes ▢ No
ADVANCED DIRECTIVE	
1. Do you have a healthcare power of attorney or a living will?	▢ Yes ▢ No

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**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 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 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

FOR OFFICE CODING: Total Score: _______ = *0* **+** _______ **+** _______ **+** _______

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**
☐	☐	☐	☐

DATE: _______________ NAME: _______________________ Date Of Birth: _____________

Social Determination of Health Form

Housing

1. What is your housing situation today?
   - ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living on the street, in a car, abandoned building, bus or train station, in a park).
   - ☐ I have housing today, but am worried about losing housing in the future.
   - ☐ I have housing, and I am not worried.

2. Think about the place you live. Do you have problems with any of the following?
   ☐ Bug Infestation ☐ Mold ☐ Lead paint or pipes ☐ Water Leaks
   ☐ Inadequate Heat ☐ Oven or stove nor working
   ☐ None or not working smoke detectors ☐ No problems

Food

1. Within the past 12 months, you were worried that your food would run out before you got money to buy more.
   ☐ Often true ☐ Sometimes true ☐ Never true
2. 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

Personal Safety

1. How often does anyone, including family, physically hurt you?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequent
2. How often does anyone, including family, insult or talk down to you?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequent
3. How often does anyone, including family, threaten you with harm?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequent
4. How often does anyone, including family, scream or curse at you?
   ☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequent

Assistance

Would you like help with any of these needs? ☐ Yes ☐ No

ICD Code: **Z13.9**
CPT code neg screening: **G9920** positive screening: **G9919**