Patient Name: _____ DOB: _____ Date: _____

Activities of Daily Living

Living *Abled* and Healthy

Checklist

Basic Activities of Daily Living

FUNCTION	NO PROBLEM	MILD DIFFICULTY	MODERATE DIFFICULTY	MAJOR DIFFICULTY	UNABLE TO DO
Bathing and showering (washing our body)					
Bowel and bladder control					
Dressing					
Eating (including chewing and swallowing)					
Feeding (setting up food and bringing it to the mouth)					
Functional mobility (moving self from one place to another)					
Personal device care					
Personal hygiene and grooming (including brushing/combing/styling hair)					
Sexual activity					
Sleep/rest					
Toilet hygiene (including urinating/defecating)					

Instrumental Activities of Daily Living

FUNCTION	NO PROBLEM	MILD DIFFICULTY	MODERATE DIFFICULTY	MAJOR DIFFICULTY	UNABLE TO DO
Care of others (incl. selecting and supervising caregivers)					
Care of pets					
Child rearing					
Communication device use					
Community mobility					
Financial management					
Health management and maintenance					
Meal preparation and cleanup					
Religious observances					
Safety procedures and emergency responses					
Shopping					

Based on Youngstrom MJ. "Occupational Therapy Practice Framework: The Evolution of Our Professional Language." *Am J Occup Ther*. 2002;56:609–639. Used by permission.

rev. 2014060102

Date: _____

Patient Name: _____

Patient DOB: _____

FALL PREVENTION SURVEY

1. Have you fallen in the last six months?

2. If you have fallen, did you sustain an injury?

3. When you have fallen or had a near fall, did you report it to anyone? (Caregiver, Family Member, Doctor, Nurse, Paramedics)

4. Do you report hazardous conditions in the community in order to prevent others from also possibly experiencing a fall?

5. Have you been assessed by your physician, caregiver, or fitness instructor for your risk of falling?

6. Have you made changes in your home to help reduce your risk of falling? If so, what kind of changes?

7. Has anyone helped you make these changes? If so, who? (contractor, carpenter/handyman, health professionals, family, home visitor, etc.)?

8. Do you feel that your current living environment is safe and without risk of injury?

9. Do you feel that your cities streets, bus stops, municipal buildings are adequately maintained? Are there fall hazards at these areas? What fall hazards have you noticed?

10. Have you received any information (pamphlets, presentations, public service announcements) on how to reduce your risk of falls? Who gave you this information?

11. Has your doctor or pharmacist talked to you about how the medication you are taking can impact your balance?

12. Are you aware of any services that can help you reduce your risk of falls (balance and mobility classes, strength training classes, substance abuse programs, vision screening, home modification programs)? If yes, are these classes appropriate and affordable for seniors?

13. If you have been injured from a fall, did hospital discharge or your doctor provide you with any information on programs and services available to you to reduce future risk of falling?

Functional Vision Screening Questionnaire

Patient Name:	Patient D.O.B.:	Visit Date:

Question:	Options	Answer
1. Do you ever feel that problems with your vision make it difficult for you to do the things you would like to do?	**1. Yes** **0. No**	
2. Can you see the large print headlines in the newspaper?	**0. Yes** **1. No**	
3. Can you see the regular print in newspapers, magazines and books?	**0. Yes** **1. No**	
4. Can you see the numbers and names in a telephone directory?	**0. Yes** **1. No**	
5. When you are walking in the street, can you see the "walk" sign and street name signs?	**0. Yes** **1. No**	
6. When crossing the street, do the cars seem to appear very suddenly?	**1. Yes** **0. No**	
7. Does trouble with your vision make it difficult for you to watch TV, play cards, do sewing, or any similar type of activity?	**1. Yes** **0. No**	
8. Does trouble with your vision make it difficult for you to see labels on medicine bottles?	**1. Yes** **0. No**	
9. Does trouble with your vision make it difficult for you to read prices when you shop?	**1. Yes** **0. No**	
10. Does trouble with your vision make it difficult to read your own mail?	**1. Yes** **0. No**	
11. Does trouble with your vision make it difficult to read your own handwriting?	**1. Yes** **0. No**	
12. Can you recognize the faces of family or friends when they are across and average size room?	**0. Yes** **1. No**	
13. Do you have and particular difficulty seeing in dim light?	**1. Yes** **0. No**	
14. Do you tend to sit very close to the television?	**1. Yes** **0. No**	
15. Has a Doctor ever told you that nothing more can be done for your vision?	**1. Yes** **0. No**	
Total:		

Patient Name: _____

Date of Birth: _____

Date of Visit: _____

GAD-7

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

(*For office coding: Total Score T*____ = ____ + ____ + ____)

Geriatric Depression Scale (Short Form)

Patient's Name: _____ Date: _____
DOB: _____

Instructions: Choose the best answer for how you felt over the past week. Note: when asking the patient to complete the form, provide the self-rated form (included on the following page).

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	YES / ***NO***	
2.	Have you dropped many of your activities and interests?	***YES*** / NO	
3.	Do you feel that your life is empty?	***YES*** / NO	
4.	Do you often get bored?	***YES*** / NO	
5.	Are you in good spirits most of the time?	YES / ***NO***	
6.	Are you afraid that something bad is going to happen to you?	***YES*** / NO	
7.	Do you feel happy most of the time?	YES / ***NO***	
8.	Do you often feel helpless?	***YES*** / NO	
9.	Do you prefer to stay at home, rather than going out and doing new things?	***YES*** / NO	
10.	Do you feel you have more problems with memory than most people?	***YES*** / NO	
11.	Do you think it is wonderful to be alive?	YES / ***NO***	
12.	Do you feel pretty worthless the way you are now?	***YES*** / NO	
13.	Do you feel full of energy?	YES / ***NO***	
14.	Do you feel that your situation is hopeless?	***YES*** / NO	
15.	Do you think that most people are better off than you are?	***YES*** / NO	
		TOTAL	

(Sheikh & Yesavage, 1986)

Scoring:

Answers indicating depression are in bold and italicized; score one point for each one selected. A score of 0 to 5 is normal. A score greater than 5 suggests depression.

Sources:

- Sheikh JI, Yesavage JA. Geriatric Depression Scale (GDS): recent evidence and development of a shorter version. *Clin Gerontol*. 1986 June;5(1/2):165-173.
- Yesavage JA. Geriatric Depression Scale. *Psychopharmacol Bull*. 1988;24(4):709-711.
- Yesavage JA, Brink TL, Rose TL, et al. Development and validation of a geriatric depression screening scale: a preliminary report. *J Psychiatr Res*. 1982-83;17(1):37-49.

Geriatric Depression Scale (Short Form)
Self-Rated Version

Patient's Name: _____ Date: _____
DOB: _____

***Instructions*: Choose the best answer for how you felt over the past week.**

No.	Question	Answer	Score
1.	Are you basically satisfied with your life?	YES / NO	
2.	Have you dropped many of your activities and interests?	YES / NO	
3.	Do you feel that your life is empty?	YES / NO	
4.	Do you often get bored?	YES / NO	
5.	Are you in good spirits most of the time?	YES / NO	
6.	Are you afraid that something bad is going to happen to you?	YES / NO	
7.	Do you feel happy most of the time?	YES / NO	
8.	Do you often feel helpless?	YES / NO	
9.	Do you prefer to stay at home, rather than going out and doing new things?	YES / NO	
10.	Do you feel you have more problems with memory than most people?	YES / NO	
11.	Do you think it is wonderful to be alive?	YES / NO	
12.	Do you feel pretty worthless the way you are now?	YES / NO	
13.	Do you feel full of energy?	YES / NO	
14.	Do you feel that your situation is hopeless?	YES / NO	
15.	Do you think that most people are better off than you are?	YES / NO	
		TOTAL	

(Sheikh & Yesavage, 1986)

Patient Name: _____ DOB: _____ Date: _____

Hearing Handicap Inventory for the Elderly Screening Version (HHIE-S; Ventry & Weinstein, 1983)

Please check "yes," "no," or "sometimes" in response to each of the following items. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer the way you hear **with*** the aid.

E = emotional S = social "No" response = 0 "Sometimes" = 2 "Yes" = 4

			Yes	Sometimes	No
E	1.	Does a hearing problem cause you to feel embarrassed when you meet new people?			
E	2.	Does a hearing problem cause you to feel frustrated when talking to members of your family?			
S	3.	Do you have difficulty hearing when someone speaks in a whisper?			
E	4.	Do you feel handicapped by a hearing problem?			
S	5.	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?			
S	6.	Does a hearing problem cause you to attend religious services less often than you would like?			
E	7.	Does a hearing problem cause you to have arguments with family members?			
S	8.	Does a hearing problem cause you difficulty when listening to TV or radio?			
E	9.	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
S	10.	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			
Score _____					

HHIE-S Score Interpretation (Lichtenstein, Bess, & Logan, 1988)

Raw Score Handicap Range Post hoc Prob. of Hearing Impairment 0– 8 No handicap 13% 10–24 Mild-moderate handicap 50% 26–40 Severe handicap 84%

*Note: This is a modification of the actual instructions, which use the word "without" to measure hearing handicap.

URINARY CONTINENCE ASSESSMENT & IMPLEMENTATION FORM

Patient _____

D.O.B.: _____ Date: _____

Current Product Information: Size: _____ Type: _____ Frequency of Leakage: _____ times/week ❑ None

I. Determine Type of Incontinence

Patient **is continent** ..... N Y → *proceed to section 2*

QUESTIONS

Do you leak when you cough, sneeze, exercise, laugh? ..... N Y → stress
Do you need to rush suddenly to toilet? ..... N Y → urge
Do you sometimes not make it to the toilet? ..... N Y → urge
Do you urinate more than 7 times/day or 2 times/night? ..... N Y → urge
Do you have a weak stream of urine? ..... N Y → overflow
Do you have frequent dribbling? ..... N Y → overflow
Do you have burning or blood in urine? ..... N Y → transient

CHART

Is the incontinence related to something other than urinary tract, such as inability to undo a zipper? ..... N Y → functional

Does the resident take stool softeners, antipsychotic, anticholergenic, narcotic analgesics, or other drugs that may affect continence? ..... N Y → further evaluation may be necessary