Patient Name: _____ Date: _____

Please complete the front and back of this page.

1. **Pain:** Please rate your pain level over the last 48 hours by placing a vertical line on the line below.

No Pain Pain as bad as it can be

2. **Depression (age 12 and older):** Do you currently have a diagnosis of depression or bipolar disorder?

_____ Yes. If yes, proceed to question # 3

_____ No. If no, please answer the questions in the following table:

(PHQ9) **Over the last 2 weeks, how often have you been bothered by any of the following problems?**	**Not at all (0)**	**Several days (1)**	**More than half the days (2)**	**Nearly every day (3)**
1) Little interest or pleasure in doing things				
2) Feeling down, depressed, or hopeless				
3) Trouble falling or staying asleep, or sleeping too much				
4) Feeling tired or having little energy				
5) Poor appetite or overeating				
6) Feeling bad about yourself or that you are a failure or have let yourself or your family down				
7) Trouble concentrating on things, such as reading the newspaper or watching television				
8) Moving or speaking so slowly that other people could have noticed OR being so fidgety or restless that you have been moving around a lot more than usual?				
9) Thoughts that you would be better off dead or of hurting yourself in some way				

3. **Please answer the following questions (age 65 and older):** *(EASI)*

1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	Yes	No
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids or medical care, or from being with people you wanted to be with?	Yes	No
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Yes	No
4) Has anyone tried to force you to sign papers or to use your money against your will?	Yes	No
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No

(Question # 4 on back) ....

4. **Are you currently diagnosed with dementia?** (complete the table below ONLY if there is a diagnosis of dementia)

____ No, I am not currently diagnosed with dementia. If "no", turn this form back into the front desk.

____ Yes, I have a diagnosis of dementia. If "yes", complete the table below.

Please check either the "Independent" OR "Dependent" box for each activity (any age): *(Katz Index)*

Activity	Independent (1 point)	Dependent (0 points)
Bathing	□Bathes self completely or needs help in bathing only a single part of the body such as back, genital area or disabled extremity	□Need help with bathing more than one part of the body, getting in or out of tub or shower, or requires total bathing
Dressing	□Get clothes from closets and drawers and puts on clothes & outer garments complete with fasteners. May have help tying shoes.	□Needs help with dressing self or needs to be completely dressed.
Toileting	□Goes to toilet, gets on & off, arranges clothes, cleans genital area without help.	□Needs help transferring to the toilet, cleaning self or uses bedpan or bedside commode
Transferring	□Moves in and out of bed or chair unassisted. Mechanical transfer aids are acceptable.	□Needs help in moving from bed to chair or requires a complete transfer.
Continence	□Exercises complete self-control over urination and defecation.	□Is partially or totally incontinent of bowel or bladder
Feeding	□Gets food from plate into mouth without help. Preparation of food may be done by another person.	□Needs partial or total help with feeding or requires parenteral feeding (i.e. feeding tube or port).