iMED Healthcare Associates
ASSESSMENT OF ACTIVITIES OF DAILY LIVING

Patient Name_____ Date_____

ACTIVITIES OF DAILY LIVING

ACTIVITY	Need no help	Need some help	Unable to do at all
Use telephone			
Getting to places beyond walking distance			
Grocery shopping			
Preparing meals			
Doing housework or handyman work			
Doing laundry			
Taking medications			
Managing money			
Total Score			

Ten Ways to Recognize Hearing Loss

The following questions will help determine if you need to have your hearing evaluated by a medical professional:

Do you have a problem hearing over the telephone?	Yes ☐	No ☐
Do you have trouble following the conversation when two or more people are talking at the same time?	Yes ☐	No ☐
Do people complain that you turn the TV volume up to high?	Yes ☐	No ☐
Do you have to strain to understand conversation?	Yes ☐	No ☐
Do you have trouble hearing in a noisy background?	Yes ☐	No ☐
Do you find yourself asking people to repeat themselves?	Yes ☐	No ☐
Do many people you talk to seem to mumble (not speak clearly)?	Yes ☐	No ☐
Do you misunderstand what others are saying and respond inappropriately?	Yes ☐	No ☐
Do you have trouble understanding women and children?	Yes ☐	No ☐
Do people get annoyed because you misunderstand them?	Yes ☐	No ☐

Three or more yes answers to these ten questions may indicate a hearing problem and a hearing evaluation by a medical specialist is recommended.

Home Safety Questionnaire

Patient Name _____ Date _____

When you are prone to falling, your home can either support you or become a reason for your falls. The following is a list of common things that make a difference in a falling problem.

Look around you and answer the questions truthfully about how well your home is helping you avoid falling. Then think about how you can change things to make it less likely that you will fall. **Bring this form with you for your evaluation.**

Please choose the best response to each of the questions below.

1. As I move from room to room in my house, I slip or stumble from clutter of electrical cords, low furniture, or other things in my path:

   Never ☐ **Rarely** ☐ **Once a week** ☐ **More than once a week** ☐

2. As I move from room to room in my house there are sturdy things I can grab to steady myself if I feel unsteady:

   Everywhere ☐ **Most Places** ☐ **Sometimes** ☐ **Few things to steady me** ☐

3. I have good light when I walk in my house, (include nighttime trips to the toilet):

   Always ☐ **Almost Always** ☐ **Sometimes** ☐ **Often dark** ☐

4. While inside my home I walk in shoes, not barefoot or in slippers:

   Often ☐ **Usually** ☐ **Sometimes** ☐ **Mostly barefoot** ☐

5. I slip or have difficulty getting on and off the toilet:

   Never ☐ **Rarely** ☐ **Sometimes** ☐ **Often** ☐

6. I slip or have difficulty getting in and out of the bath or shower:

   Never ☐ **Rarely** ☐ **Sometimes** ☐ **Often** ☐

7. I slip or have difficulty with steps or stairs in my house

   Never ☐ **Rarely** ☐ **Sometimes** ☐ **Often** ☐

8. I stand on my toes to get things out of reach in my kitchen or closets

   Never ☐ **Rarely** ☐ **Sometimes** ☐ **Often** ☐

9. In the places I walk outside, there are uneven surfaces, cracked sidewalks, slippery steps, or other problems, that make me trip or stumble.

   Never ☐ **Rarely** ☐ **Sometimes** ☐ **Often** ☐

10. If I were to fall, hurt myself, and were unable to get up, I would be able to get help quickly.

    Always ☐ **Usually** ☐ **Sometimes** ☐ **No – Usually Alone** ☐

PATIENT NAME _____ DATE _____

Choose the best answer for how you felt this week.

	CIRCLE ONE
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 hopeful about the future?	Yes ☐ No ☐
6. Are you bothered by thoughts you can't get out of your head?	Yes ☐ No ☐
7. Are you in good spirits most of the time?	Yes ☐ No ☐
8. Are you afraid that something bad is going to happen to you?	Yes ☐ No ☐
9. Do you feel happy most of the time?	Yes ☐ No ☐
10. Do you often feel helpless?	Yes ☐ No ☐
11. Do you often get restless and fidgety?	Yes ☐ No ☐
12. Do you prefer to stay at home, rather than going out and doing new things?	Yes ☐ No ☐
13. Do you frequently worry about the future?	Yes ☐ No ☐
14. Do you feel you have more problems with memory than most?	Yes ☐ No ☐
15. Do you think it is wonderful to be alive now?	Yes ☐ No ☐
16. Do you often feel downhearted and blue?	Yes ☐ No ☐
17. Do you feel pretty worthless the way you are now?	Yes ☐ No ☐
18. Do you worry a lot about the past?	Yes ☐ No ☐
19. Do you find life very exciting?	Yes ☐ No ☐
20. Is it hard for you to get started on new projects?	Yes ☐ No ☐

21. Do you feel full of energy? Yes ☐ No ☐

22. Do you feel that your situation is hopeless? Yes ☐ No ☐

23. Do you think that most people are better off than you are? Yes ☐ No ☐

24. Do you frequently get upset over little things? Yes ☐ No ☐

25. Do you frequently feel like crying? Yes ☐ No ☐

26. Do you have trouble concentrating? Yes ☐ No ☐

27. Do you enjoy getting up in the mornings? Yes ☐ No ☐

28. Do you prefer to avoid social gatherings? Yes ☐ No ☐

29. Is it easy for you to make decisions? Yes ☐ No ☐

30. Is your mind as clear as it used to be? Yes ☐ No ☐

Score _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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 figety 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	0 ☐	1 ☐	2 ☐	3 ☐
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: 0

10. 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 ☐

A2663B 10-04-2005