

CONTACT INFORMATION

<p>Legal Name: _____ <small>First Middle Last</small></p> <p>Preferred Name _____</p> <p>Primary Language _____</p>	<p>Date: / /</p>
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<p>Address:</p> <p>Street _____</p> <p>City _____</p> <p>State _____</p> <p>Zip _____</p> <p>County _____</p>	<p>Phone/Email: Check boxes if it's ok to Call (C) and/or Leave Messages (LM) C LM</p> <p>Home _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>Cell _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>Work _____ <input type="checkbox"/> <input type="checkbox"/></p> <p style="text-align: right;">OK to Send Info?</p> <p>Email _____ <input type="checkbox"/></p>
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<p><i>I understand that in the event Aging Center staff are concerned about my safety because he or she was unable to get a hold of me at our scheduled appointment time, I give my permission for my therapist to contact my Emergency Contact as listed above. I understand that no information will be released other than that related to the concern about my safety, unless legal requirements relating to the reporting of threats of violence, harm or child or elder abuse or neglect apply.</i></p>	<p>Referred By: _____</p> <p>How did you hear about our services? _____</p>
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<p>Emergency Contact: _____ <small>First Last</small></p> <p>Relationship _____</p> <p>Phone _____</p>	<p>Are you receiving other services in this building?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, List Clinics _____</p>
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DEMOGRAPHIC INFORMATION

1. Date of Birth: _____ / _____ / _____	2. Age: _____
3. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	4. Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Prefer not to answer
5. Education Level: <input type="checkbox"/> Less than High School <input type="checkbox"/> High School/GED <input type="checkbox"/> Some College <input type="checkbox"/> Bachelor’s Degree <input type="checkbox"/> Graduate or Professional Degree	6. Race: (check all that apply) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Prefer not to answer
7. Marital and Partner Status: <input type="checkbox"/> Never Married or Partnered <input type="checkbox"/> Married <input type="checkbox"/> Committed Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	8. Sexual Orientation: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual/Lesbian/Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Other: _____ <input type="checkbox"/> Prefer not to answer
9. Employment Status: <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-time <input type="checkbox"/> Retired <input type="checkbox"/> Volunteering <input type="checkbox"/> Seeking Employment <input type="checkbox"/> Not Employed	10. Annual Household Income: <input type="checkbox"/> \$0-15,000 <input type="checkbox"/> \$15,001-45,000 <input type="checkbox"/> \$45,001-75,000 <input type="checkbox"/> \$75,001+ 10b. # of people supported: _____
11. Type of work <input type="checkbox"/> Desk job/sedentary <input type="checkbox"/> Physical labor <input type="checkbox"/> Standing or light walking <input type="checkbox"/> Not currently working <input type="checkbox"/> Other: _____	12. Disability Income: <input type="checkbox"/> No <input type="checkbox"/> Yes, List disability: _____ _____ _____
13. Military: <input type="checkbox"/> No Military Background <input type="checkbox"/> Active Duty Service Member <input type="checkbox"/> Retired Service Member <input type="checkbox"/> Active Duty Family Member <input type="checkbox"/> Retired Family Member <input type="checkbox"/> Reserves <input type="checkbox"/> Former Military <input type="checkbox"/> Former Military Family Member	14. Family changes in last 12 months? (check all that apply) <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Births <input type="checkbox"/> Deaths <input type="checkbox"/> Other, List: _____

15. Children (including step-children) and Others living in your home:					
First Name & Relationship	Age	Live with you?	First Name & Relationship	Age	Live with you?
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No



YOUR HEALTH

Allergies

1. Do you have any medical allergies? No Yes If yes, List:

SYMPTOM/PROBLEM

2. Do you currently have symptoms or problems that led you to come in today? No Yes

3. If yes, Please list any symptoms or problems you have and rate the frequency and intensity for each.

3.a.	Frequency	Rare						Almost constant
		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
	Intensity	Barely noticeable				Very intense		
		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
3.b.	Frequency	Rare						Almost constant
		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
	Intensity	Barely noticeable				Very intense		
		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
3.c.	Frequency	Rare						Almost constant
		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
	Intensity	Barely noticeable				Very intense		
		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
3.d.	Frequency	Rare						Almost constant
		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
	Intensity	Barely noticeable				Very intense		
		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

ALCOHOL AND DRUG USE

1 drink of alcohol is defined as any one of the following:

- 12 fl oz of beer
- 5 fl oz of table wine
- 1 shot of liquor



1. Alcohol (drinks per week): _____
2. Have you used alcohol excessively *in the past year*? No Yes
3. Have you *ever* used alcohol excessively? No Yes
4. Has anyone in your family *ever* used alcohol excessively? No Yes
5. Caffeine (cups or cans per day) _____ Caffeine is contained in: Coffee, Tea, Soda and Energy Drinks
6. Tobacco (amount per day): _____
7. Has anyone in your family *ever* used tobacco? No Yes
8. E-cigarette or Vaporizer (amount per day): _____
9. Do you use marijuana? No Yes Frequency: _____
Purpose: _____
10. Have you used recreational drugs (drugs not prescribed to you) *in the past year*? No Yes List: _____
11. Have you *ever* used recreational drugs? No Yes List: _____
12. Has anyone in your family *ever* used recreational drugs? No Yes List: _____

PRESCRIBED MEDICATIONS (include those prescribed by a health provider)

PRESCRIPTION MEDICATIONS			OVER-THE-COUNTER MEDICATIONS OR NATURAL SUPPLEMENTS		
Name of Medication	Dose	Frequency	Name of Medication	Dose	Frequency

PROMIS – Global Health

Please respond to each item by marking one box per row.

	Excellent	Very good	Good	Fair	Poor						
1. In general, would you say your health is:	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
2. In general, would you say your quality of life is:	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
3. In general, how would you rate your physical health?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
4. In general, how would you rate your mental health, including your mood and your ability to think?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
5. In general, how would you rate your satisfaction with your social activities and relationships?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
6. In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1						
7. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	Completely <input type="checkbox"/> 5	Mostly <input type="checkbox"/> 4	Moderately <input type="checkbox"/> 3	A little <input type="checkbox"/> 2	Not at all <input type="checkbox"/> 1						
8. In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	Never <input type="checkbox"/> 5	Rarely <input type="checkbox"/> 4	Sometimes <input type="checkbox"/> 3	Often <input type="checkbox"/> 2	Always <input type="checkbox"/> 1						
9. In the past 7 days, my sleep quality was	Very poor <input type="checkbox"/> 1	Poor <input type="checkbox"/> 2	Fair <input type="checkbox"/> 3	Good <input type="checkbox"/> 4	Very good <input type="checkbox"/> 5						
10. In the past 7 days, how would you rate your fatigue on average?	None <input type="checkbox"/> 5	Mild <input type="checkbox"/> 4	Moderate <input type="checkbox"/> 3	Severe <input type="checkbox"/> 2	Very Severe <input type="checkbox"/> 1						
11. In the past 7 days, how would you rate your pain on average?	No Pain		Worst imaginable Pain								
	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10

12. Location of Pain:

HEALTH HISTORY

<p>1. Visual Difficulties:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cataracts <input type="checkbox"/> Diabetic retinal disease <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Hypertensive retinal disease <input type="checkbox"/> Glaucoma <input type="checkbox"/> Other, describe: _____ 	<p>2. Hearing Difficulties:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hearing aids <input type="checkbox"/> Hearing Problems without aids <input type="checkbox"/> Other, describe: _____
<p>3. Mobility Assistive Devices:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Prosthesis <input type="checkbox"/> Other, describe: _____ 	

For each item listed indicate your lifetime, past year and family history by placing a check in the column.

Self: Lifetime - Applies to you at **ANY** time in your life.

Self: Past Year - YOU have had in the **past 12 months**.

Family – (Left side only) Any of the following that *your mother, father, or siblings* have ever had.

Self		Family		Self		
Life-time	Past Year			Life-time	Past Year	
			Abnormal heart rhythm			Immunizations up to date
			Alzheimer's/Dementia			Use birth control
			Arthritis			Ever been pregnant
			Asthma			Sexually transmitted diseases
			Bone density problems (osteoporosis or osteopenia)			Had abortion, miscarriage or still birth
			Cancer			Wear bike helmet
			Chicken pox			Use seat belt regularly
			Depression			Exercise regularly
			Diabetes			Special diet, List:
			Eating disorder			Digestion issues:
			Gastritis/ulcer			Gas
			Heart attack			Bloat
			Heart disease			Constipation
			High blood pressure			Diarrhea
			High cholesterol			Falls: How many in past year? __
			Kidney problems			Headaches
			Liver problems			Head Injury
			Measles			Serious Injury
			Mumps			Bone fractures
			Other mental health problem			Joint replacement
			Rheumatic fever			Back pain
			Stroke			Numbness
			Thyroid problems			Tingling
			Tuberculosis			Swelling
						Traumatic event
						Exposure to chemicals
						Feel safe in relationships
						Physical abuse
						Sexual abuse
						Suicide attempt
SURGICAL HISTORY (lifetime)						
Year		Describe				

SCREEN IIAB

For each question, check only one box that describes you best. Your response should reflect your typical eating habits. Feel free to write comments beside any question.

1. Has your weight changed in the past 6 months?

No/Unsure

 8

No, my weight stayed within a few pounds.

 0

I don't know how much I weigh or if my weight has changed.

Yes, I **gained** . . .

 0

More than 10 pounds

 2

6 to 10 pounds

 4

About 5 pounds

Yes, I **lost** . . .

 0

More than 10 pounds

 2

6 to 10 pounds

 4

About 5 pounds

2. Do you skip meals?

Never or rarely

 8

Sometimes

 4

Often

 2

Almost every day

 0

3. How would you describe your appetite?

Very good

 8

Good

 4

Fair

 2

Poor

 0

4. Do you cough, choke or have pain when swallowing food OR fluids?

Never

 8

Rarely

 4

Sometimes

 2

Often or always

 0

5. How many pieces or servings of fruit and vegetables do you eat in a day?

Fruit and vegetables can be canned, fresh, frozen, or juice.

Five or more

 4

Four

 3

Three

 2

Two

 1

Less than two

 0

6. How much fluid do you drink in a day?

Examples are water, tea, coffee, herbal drinks, juice, and soft drinks, but not alcohol.

Eight or more cups

 4

Five to seven cups

 3

Three to four cups

 2

About two cups

 1

Less than two cups

 0

7. Do you eat one or more meals a day with someone?

Never or rarely

 8

Sometimes

 4

Often

 2

Almost always

 0

8. Which statement best describes meal preparation for you?

 4

I enjoy cooking most of my meals.

 2

I *sometimes* find cooking a chore.

 0

I *usually* find cooking a chore.

 4

I'm *satisfied* with the quality of food prepared by others.

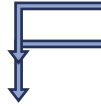
 0

I'm *not satisfied* with the quality of food prepared by others.

PHYSICAL ACTIVITY

1a. Are you regularly physically active for approximately 150 mins/week or 30 mins/day on most days?

- Yes: I have been physically active for more than 6 months
- Yes: I have become physically active within past 6 months
- Yes: I am physically active once in a while, not consistently
- No: I have been thinking about becoming physically active, not yet
- No: I am not physically active, nor planning to become physically active



1b. If no, how long has it been since you have been physically active? _____ (months)

2. When are you physically active?

- At work
- At home
- Transportation
- Leisure time
- Other, describe:

3. What type of physical activities are you currently performing? (Check all that apply)

- Not physically active
- Walking
- Hiking
- Jogging/running
- Stretching
- Team sports
- Pilates
- Group fitness class
- Yoga
- Golf
- Strength training
- Cycling
- Tennis
- Pickleball
- Tai Chi
- Meditation
- Other, Describe:

4. In the past 7 days, how often did you do the following types of activities . . .

Number of days you did this activity

Average number of minutes/day?

4. In the past 7 days, how often did you do the following types of activities . . .	Number of days you did this activity	Average number of minutes/day?
4a. Vigorous physical activity		
4b. Walking		
4c. Sitting		

5. What time of day are you typically physically active?

- Not physically active
- Morning
- Afternoon
- Evening

6. Which social context do you prefer for workouts?

- Not currently active
- Myself/alone
- Trainer/coach
- Friend
- Family member
- With a small group/team
- With a large group/team

7. Has a healthcare professional suggested physical activity for any of the following symptoms: (Check all that apply)

- Arthritis
- Anxiety
- Fatigue
- Depression
- Stress
- Weight gain
- Pain
- Poor sleep
- Other, Describe: _____



Concerns

What concerns, if any, do you have about your memory?

Have you ever been evaluated for a memory problem?

- No
- Yes

If yes, please list when and where you were evaluated, (e.g. Memorial Hospital, 1999):

Do you have any difficulty performing any of the following tasks? (check all that apply)

- Preparing meals
- Shopping
- Managing your money
- Housekeeping
- Taking Medications
- Eating
- Bathing
- Dressing
- Toileting
- Getting in or out of bed or a chair
- Maintaining continence
- None of the above

Memory

This is a set of questions about minor memory mistakes that everyone makes from time to time. Please check the answer that describes how often you do each of these things.

	Very Often	Quite Often	Sometimes	Rarely	Never
1. Do you decide to do something in a few minutes' time and then forget to do it?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
2. Do you fail to recognize a place you have visited before?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
3. Do you fail to do something you were supposed to do a few minutes later even though it's there in front of you, like take a pill or turn off the kettle?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
4. Do you forget something that you were told a few minutes before?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
5. Do you forget appointments if you are not prompted by someone else or by a reminder such as a calendar or diary?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
6. Do you fail to recognize a character in a radio or television show from scene to scene?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
7. Do you forget to buy something you planned to buy at a store, like a birthday card, even when you drive or walk by the store?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
8. Do you fail to recall things that have happened to you in the last few days?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
9. Do you repeat the same story to the same person on different occasions?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
10. Do you intend to take something with you, before leaving a room or going out, but minutes later leave it behind, even though it's there in front of you?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1



	Very Often	Quite Often	Sometimes	Rarely	Never
11. Do you forget where you left something that you have just put down, like a magazine or eyeglasses?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
12. Do you fail to mention or give something to a visitor that you were asked to pass on?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
13. Do you look at something without realizing that you have seen it moments before?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
14. If you tried to contact a friend or relative who was out, would you forget to try again later?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
15. Do you forget what you watched on television the previous day?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
16. Do you forget to tell someone something you had meant to mention a few minutes ago?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1