Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Well-Being Assessment

Please answer every question.

STAFF: Handwritten responses must be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Have you had any problems with balance or walking? yes no

Are you physically active? (e.g., walking, group classes, stationary bike, etc.) yes no

How many times per week do you get exercise? <1 1 2 3 4 5 6 7+

Have you fallen (without having been pushed) **in the last 3 months?** yes no

How many times? 1 2 3 4 5+

Were you using an assistive device? (e.g., cane, walker, wheelchair, etc.) yes no

Date the last fall occurred: _____

please fold on dotted line

Circumstances of the fall:
tripped / stumbled over something
lightheadedness / pounding heart rate
unable to get up within 5 minutes
needed assistance to get up
lost consciousness

Were you seen in the emergency room for the fall? yes no

Were there any new medications you had begun taking around the time of the fall? yes no

Do you use a device for mobility? cane walker wheelchair **other:** _____

Any recent vision changes? yes no

Any recent hearing changes? yes no

Have you had problems with urine leakage? yes no

Have you had any problems with your short-term memory?
(e.g., What did you have for dinner last night?) yes no

Have you had any problems with your long-term memory? (e.g., Where were you born?) yes no

Over the past two weeks have you felt down, depressed, or hopeless? yes no

Over the past two weeks have you felt little interest or pleasure in doing things? yes no

How would you rate your overall health? (Please select one.) poor fair good excellent

Do you have any problems completing the following activities?

please fold on dotted line

	independent	need help	totally dependent
Bathing			
Getting dressed			
Getting to and from the toilet			
Shopping			
Preparing meals			
Feeding yourself			
Using the telephone			
Housekeeping			
Laundry			
Managing medications			
Managing household finances			

Please select the number that best describes your OVERALL PAIN LEVEL:

0 No Pain | 1 Mild Pain | 2 | 3 Moderate Pain | 4 | 5 | 6 Severe Pain | 7 | 8 Very Severe | 9 | 10 Worst Possible Pain