Family Care Physicians, P.C.
Anxiety and Depression Institute

PHYSICAL QUESTIONNAIRE

PATIENT NAME:

PATIENT DOB:

TODAY'S DATE:

ADVANCE DIRECTIVES
Do you have an Advanced Directive for Healthcare? ☐ Yes ☐ No If No, would you like more information ☐ Yes
PAIN
Are you having pain today? ☐ Yes ☐ No
If yes, where is the pain located?
FUNCTIONAL ABILITY, SAFETY, HOME & ENVIRONMENT
How often do you exercise? ☐ Never ☐ Daily ☐ Weekly ☐ Monthly
Do you need help with activities of daily living? ☐ Yes ☐ No
Do you have smoke detectors in your home? ☐ Yes ☐ No
Do you have carbon monoxide detectors in your home? ☐ Yes ☐ No
Do you have firearms? ☐ Yes ☐ No if yes, are the firearms stored securely? ☐ Yes ☐ No
Do you follow a Healthy Diet?

☐ Yes	☐ No
☐ Explain:	

TOBACCO AND ALCOHOL

Do you use tobacco?

☐ Yes ☐ No ☐ Former

If Yes

☐ Cigarettes ☐ Vape ☐ Chew

Amount: Would you be interested in Quitting, ☐ Yes

Do you drink alcohol?

☐ Yes ☐ No

If yes, what types? (check all that apply)

☐ Beer ☐ Wine ☐ Hard Liqour

How frequently do you drink alcohol?

☐ Daily ☐ Weekly

☐ Socially (< 1 drink per Month)

How much alcohol do you think you drink at one time?

☐ 1-3 Drinks ☐ 4-6 Drinks

☐ 7 or more Drinks

HEALTH SCREEN HISTORY

When was your last:	Date:	Where:
Colonoscopy/Cologuard:		
Mammogram:		
Pap smear		

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Patient Health Questionnaire Depression (PHQ-9)

Date: Patient Name: Date of Birth:

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please click the check mark by your answers.

PHQ-9	**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 slowly that others could have noticed. Or the opposite – being so fidgety 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 in some way.	0 ☐	1☐	2 ☐	3 ☐
Add the score for each column				

Total Score (add your column scores):

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Please check one)

☐ **Not difficult at all.** ☐ **Somewhat difficult.** ☐ **Very Difficult.** ☐ **Extremely Difficult.**

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Patient Health Questionnaire General Anxiety Disorder (GAD-7)

Date: Patient Name: Date of Birth:

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? Please click the check mark by your answers.

GAD-7	**Not at all sure**	**Several days**	**Over 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's 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 ☐
Add the score for each column				

Total Score (add your column scores):

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Please check one)

☐ **Not difficult at all.** ☐ **Somewhat difficult.** ☐ **Very Difficult.** ☐ **Extremely Difficult.**

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Social Determinants of Health

Patient Name: (first & last)

Patient Date of Birth:

Patient Primary Care Physician:

Today's Date:

As your Patient-Centered Medical Home, we are happy to partner with you, to help you and your family in time of need. From the answers below, we maintain a list of trusted community resources that care about you as much as we do.

Please answer the following questions.			
Within the past 12 months have you worried whether your food would run out before you got money to buy more?	☐ Often	☐ Sometimes	☐ Never
Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household?	☐ Yes	☐ No	
In the past year, has the utility company shut off your service for not paying your bills?	☐ Yes	☐ No	
In the last 12 months, did you skip medications to save money?	☐ Yes	☐ No	
In the last six months, have you ever had to go without health care because you didn't have a way to get there?	☐ Yes	☐ No	
Do problems getting child care or elderly care make it difficult to work or study?	☐ Yes	☐ No	
Do you need any assistance with finding a local career center or job training?	☐ Yes	☐ No	
I have trouble understanding my doctor's written instructions.	☐ Yes	☐ No	
How often do you feel lonely?	☐ Often	☐ Sometimes	☐ Never
Do you ever feel unsafe in your home or neighborhood?	☐ Yes	☐ No	
If you answered yes, would you like to receive assistance with any of these needs?	☐ Yes	☐ No	
Can we share this information with organization to whom we make referrals to address these needs	☐ Yes	☐ No	