St. John's Health
Teton Physical Therapy & Rehabilitation
555 E. Broadway Ave Suite #100
P.O. Box 10490
Jackson, WY 83001
Phone: (307) 739-1864
Fax: (307) 739- 1831

Patient Name: _____
Date of Birth: _____
Visit Date: _____

# Connections Geriatric Assessment

1) What is your concern or reason for visit today?

_____

_____

2) Level of Education (*circle one*)

Primary School  High School Graduate  Some College
Some College  College Graduate  Post-Graduate

3) Are you currently (*circle one)*

Employed  Retired  Disabled

Usual Occupation?: _____

4) Where do you live? (*circle one*)

House or apartment  Assisted Living Facility  Nursing Home
Retirement Community  Other: _____

St. John's Health
Teton Physical Therapy & Rehabilitation
555 E. Broadway Ave Suite #100
P.O. Box 10490
Jackson, WY 83001
Phone: (307) 739-1864
Fax: (307) 739- 1831

Patient Name: _____
Date of Birth: _____
Visit Date: _____

5) Who do you live with? (*circle one*)

Alone Spouse Partner Friend

Roommate Relative Other: _____

6) How often do you get out of the house? (*circle one*)

Daily A Few Times per Week Once per week or less

7) What do you do for exercise? _____
How often do you exercise? _____

8) Do you drink alcohol? Yes/No

If yes, how often _____

9) Do you use tobacco? Yes/No

If yes, how often _____

St. John's Health
Teton Physical Therapy & Rehabilitation
555 E. Broadway Ave Suite #100
P.O. Box 10490
Jackson, WY 83001
Phone: (307) 739-1864
Fax: (307) 739- 1831

Patient Name: _____
Date of Birth: _____
Visit Date: _____

# Review of Systems:

## Neurologic

1) Do you have headaches?.....Yes No
2) Do you have trouble walking? .....Yes No
3) Have you had any falls?.....Yes No
   If yes, when and how often? Date: _____
4) Have you ever lost consciousness?.....Yes No
5) Have you ever had seizures or convulsions?.. Yes No
6) Have you ever had a stroke or TIA?.....Yes No
7) Do you have pain or numbness in your arms or legs?
   ..... Yes No
8) Do you have difficulty with sleep? .....Yes No

## Cognitive

1) Have you noticed any recent changes in your thinking?
   .....Yes No
2) Do you have difficulty remembering new information?
   .....Yes No
3) Do you have difficulty remembering past events?
   .....Yes No
4) Do you have trouble finding words? .....Yes No

St. John's Health
Teton Physical Therapy & Rehabilitation
555 E. Broadway Ave Suite #100
P.O. Box 10490
Jackson, WY 83001
Phone: (307) 739-1864
Fax: (307) 739- 1831

Patient Name: _____
Date of Birth: _____
Visit Date: _____

## Behavioral

1) Over the past 2 years have you lost interest or pleasure in doing things?.....Yes No
2) Over the past 2 years, have you felt sad, depressed or hopeless? ……Yes No
3) Do you feel anxious or fearful? ……..Yes No
4) Have you seen anything that others could not? Yes No

## Eyes

1) Do you have trouble with your vision or ever see double? ……..Yes No
2) Have you ever had an episode where you lost vision for a while? ……Yes No
3) Do you have trouble reading?.....Yes No

## Ears

1) Do you have trouble hearing?.....Yes No
2) Do you have ringing or noises in your ears?.....Yes No

## Respiratory

1) Do you ever get short of breath when walking or climbing stairs?.....Yes No
2) Do you ever wake up at night short of breath? ..Yes No

St. John's Health
Teton Physical Therapy & Rehabilitation
555 E. Broadway Ave Suite #100
P.O. Box 10490
Jackson, WY 83001
Phone: (307) 739-1864
Fax: (307) 739- 1831

Patient Name: _____
Date of Birth: _____
Visit Date: _____

3) Have you ever coughed up blood? ……..Yes No

## Cardiovascular

1) Do you have high blood pressure? ……Yes No
2) Have you ever had a heart attack, pain or tightness in your chest? ……Yes No
3) Have you ever felt that your heart was thumping or racing? ……Yes No
4) Do you have a heart murmur? ……..Yes No
5) Do you ever have swollen feet or ankles? ……Yes No

## Genitorurinary

1) Do you have a history of UTI's? ……Yes No
2) Are you ever unable to control your urine? ……Yes No

## Gastrointestinal

1) Do you ever have trouble controlling your bowels or have you ever been incontinent of bowels? ……Yes No

## Musculoskeletal

1) Do you have trouble with muscle stiffness?.....Yes No
2) Do you have pain or swelling in your joints?.....Yes No
3) Do you have back pain?.....Yes No

St. John's Health
Teton Physical Therapy & Rehabilitation
555 E. Broadway Ave Suite #100
P.O. Box 10490
Jackson, WY 83001
Phone: (307) 739-1864
Fax: (307) 739- 1831

Patient Name: _____
Date of Birth: _____
Visit Date: _____

## Endocrine

1) Do you have diabetes?.....Yes No
2) Do you have problems with your Thyroid?.....Yes No

## Medication List

(Please list all prescribed and over the counter medications you are taking currently. Include all nutritional supplements, laxatives, pain relievers, vitamins, ointments, home remedies, etc)

| Medication Name | Dose | When You Take Them | Date Begun |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

St. John's Health
Teton Physical Therapy & Rehabilitation
555 E. Broadway Ave Suite #100
P.O. Box 10490
Jackson, WY 83001
Phone: (307) 739-1864
Fax: (307) 739- 1831

Patient Name: _____
Date of Birth: _____
Visit Date: _____

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## Allergies to Medications

[ ] None known
[ ] I have an allergy to: _____
_____

## Relatives with Memory Problems

[ ] None known
[ ] Yes, please specify number and relationships: _____
_____
_____

St. John's Health
Teton Physical Therapy & Rehabilitation
555 E. Broadway Ave Suite #100
P.O. Box 10490
Jackson, WY 83001
Phone: (307) 739-1864
Fax: (307) 739- 1831

Patient Name: _____
Date of Birth: _____
Visit Date: _____