St John's HEALTH

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

Teton PHYSICAL THERAPY & REHABILITATION

555 E. Broadway Ave Suite #100
P.O. Box 1040
Jackson, WY 8301
Phone: 307.736.1864
Fax: 307.739.1831

Patient Name _____

4. Where do you live? (circle one)

House or apartment | Assisted Living Facility | Nursing Home

Retirement Community | Other: _____

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

Patient Name _____

7. What do you do for exercise?

_____

8. How often do you exercise?

_____

9. Do you drink alcohol?

☐ YES ☐ NO

If yes, how often? _____

10. Do you use tobacco?

☐ YES ☐ NO

If yes, how often? _____

Patient Name _____

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

Patient Name _____

Review of Systems: 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

Review of Systems: 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

Patient Name _____

Review of Systems: 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

Review of Systems: EARS

1. Do you have trouble hearing?

☐ YES ☐ NO

2. Do you have ringing or noises in your ears?

☐ YES ☐ NO

Patient Name _____

Review of Systems: 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

3. Have you ever coughed up blood?

☐ YES ☐ NO

Review of Systems: 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

Patient Name _____

Review of Systems: CARDIOVASCULAR (continued)

4. Do you have a heart murmur?

☐ YES ☐ NO

5. Do you ever have swollen feet or ankles?

☐ YES ☐ NO

Review of Systems: GENITORURINARY

1. Do you have a history of UTI's?

☐ YES ☐ NO

2. Are you ever unable to control your urine?

☐ YES ☐ NO

3. Do you ever have trouble controlling your bowels or have you ever been incontinent of bowels?

☐ YES ☐ NO

Patient Name _____

Review of Systems: 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

Review of Systems: ENDOCRINE

1. Do you have diabetes?

☐ YES ☐ NO

2. Do you have problems with your thyroid?

☐ YES ☐ NO

Patient Name _____

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

Patient Name _____

Allergies to Medications

[ ] *None known*

[ ] *I have an allergy to:* _____

_____

_____

_____

Relatives with Memory Problems

[ ] *None known*

[ ] *Yes, please specify number and relationships:* _____

_____

_____

_____

Patient Name _____

Changes in Your Daily Life

Please fill out this activity list by placing an 'X' in the column that best describes your situation:

Activity	No problem, never did, but could have a problem now	Have difficulty but does by self; never did but would have difficulty now	Need Assistance	Can't do
Writing checks, paying bills, balancing checkbooks				
Assembling tax records, business affairs, paperwork				
Shopping alone for groceries, clothes or household items				
Playing a game of skill, working on a hobby				
Heating water, making a cup of coffee, turning on the stove				

Patient Name _____

Changes in Your Daily Life

Please fill out this activity list by placing an 'X' in the column that best describes your situation:

Activity	No problem	Have difficulty but does by self; never did but would have difficulty now	Need Assistance	Can't do
Preparing a balanced meal				
Keeping track of current events				
Paying attention to, understanding, discussing tv show, book or magazine				
Remembering appointments, family occasions, holidays or medications				
Travelling out of the neighborhood, driving, arranging a bus				

Patient Name _____

Geriatric Depression Scale

1. Are you basically satisfied with your life?

☐ YES ☐ NO

2. Have you dropped many or 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 in good spirits most of the time?

☐ YES ☐ NO

6. Are you afraid that something bad is going to happen to you?

☐ YES ☐ NO

7. Do you often feel helpless?

☐ YES ☐ NO

8. Do you prefer to stay home, rather than go out and do new things?

☐ YES ☐ NO

9. Do you feel that you have more problems with memory than most?

☐ YES ☐ NO

10. Do you think it is wonderful to be alive now?

☐ YES ☐ NO