Surprise Health Center, PLLC

Wellness Form

Regular Adult CPX (Physical Exam, “Hands-on”)

Age: 18-39 (99395)   Age: 40-64 (99396)

ADVANCED CARE PLANNING FORM (99497, 1123F - 24F)

Patient Name: ______________________________________   **DOB:** _____/_____/_____

Advance care planning (ACP) encourages you to reflect on what is important to you, your beliefs, values, goals, and preferences in life. It explains how you want to be cared for it you reach a point where you cannot communicate decisions about your medical care. It keeps you involved in your medical decisions, both now and in the future, whether you are healthy or have an illness.

Please respond to the following:

____ Yes ____No   I have a living will

If no, would you like additional information on how to obtain one?   ____ Yes ____No

____ Yes ____No   I have a medical power of attorney

If no, would you like additional information on how to obtain one?   ____ Yes ____No

____ Yes ____No   I have chosen someone to assist in end of life medical decision making

If yes, please provide contact information:

Name: ______________________________   Phone Number: ___________________

Please Check All That Apply:

_____ I have requested a do not resuscitate order (DNR)

_____ I am an organ donor

_____ I am a tissue donor

_____ I have made a decision in regards to Feeding and hydration while in an irreversible coma or in a terminal condition

If yes, please describe decision in detail:

____   ___________________________

Patient/Guardian Signature   **Date**

Surprise Health Center, PLLC

Patient Name: ______________________________________ **DOB:** _____/_____/_____

Patient Health Questionnaire (PHQ-9) G0444

Over the past 2 weeks, how often have you been bothered by any of the following problems:	**Not at all**	**Several days**	**More than half the days**	**Nearly everyday**
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 asleep, 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're a failure or have let yourself or 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 so slowly that other people 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
If you checked off any problems, how difficult have those problems made it for you to do your work, take of things at home, or get along with other people?	Not at all	Somewhat difficult	Very difficult	Extremely difficult
Column Totals:	______ +	______ +	______ +	______

Total Score =

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Patient Name: ______________________________________ **DOB:** _____/_____/_____

Anxiety Questionnaire (GAD-7)

Over the past 2 weeks, how often have you been bothered by any of the following problems:	Not at all	Several days	More than half the days	Nearly everyday
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 asleep, 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're a failure or have let yourself or family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
If you checked off any problems, how difficult have those problems made it for you to do your work, take of things at home, or get along with other people?	Not at all	Somewhat difficult	Very difficult	Extremely difficult

Column Totals: ______ + ______ + ______ + ______

Total Score =

Audit-C Questionnaire (G0442-3)

1. How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4+ times a week

2. How many standard drinks containing alcohol do you have on a typical day?

☐ Zero ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7+

3. How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily