Combination Document: Intake, Phone Screen, and Pre-Appointment (Medical and Psychosocial History Supplement)

Caller: _____ Date: _____

Relationship to Patient: _____ Phone number: _____

Referred by: _____ Phone Number: _____

Reason for Evaluation: _____

_____

Previous Evaluation/Screening: ☐ No ☐ Yes (when and where) _____

Patient's Name: _____ Date: _____

Address: _____ City: _____ Zip Code: _____

DOB: _____ Age: _____ Gender: ☐ Female ☐ Male

Marital status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient lives: ☐ by self ☐ with spouse/partner ☐ with family/other: _____

Primary Language: _____ ☐ Interpreter Needed

Primary Care Provider: _____ Affiliation/clinic: _____ Phone: _____

Date last seen: _____ Date of Last Physical: _____

Hospitalizations: _____

Other Healthcare Provider: _____ Specialty: _____

Other Healthcare Provider: _____ Specialty: _____

Health Insurance: _____

Scheduled Phone Interview: _____

Notes: _____

_____

Send correspondence to: ☐ Patient ☐ Other:_____

Health record information

Phone Screen
Goals for appointment:

Concerns/Symptoms:

- ☐ Curious/wanted to check out what a screening is
- ☐ Memory problems
- ☐ Confusion
- ☐ Disorientation: place / person / time
- ☐ Speech changes: repetitive / rambling / word-finding difficulties
- ☐ Misplacing items
- ☐ Problems managing: finances / medications
- ☐ Decline in: hygiene / bathing / dressing / cooking
- ☐ Concerns about judgment or decision-making
- ☐ Weight loss or gain
- ☐ Getting lost / wandering / elopement
- ☐ Someone else encouraged them to go
- ☐ Depressive symptoms
- ☐ Nervousness / restlessness / anxiety
- ☐ Suspiciousness / paranoia
- ☐ Obsessions
- ☐ Agitation / aggressive behavior
- ☐ Delusions
- ☐ Hallucinations: visual / auditory / olfactory
- ☐ Sleep disturbance
- ☐ Inappropriate or unusual behavior
- ☐ Driving concerns

Additional information/comments:

☐ No history of formal mental health or chemical dependency treatment, or trials of psychotropic medications.
☐ Mental health or chemical dependency treatment (indicate whether outpatient or inpatient and provider): _____

_____

☐ Psychotropic medications (hx/current): _____

_____

Power of Attorney – Health Care (POA-HC) ☐ No ☐ Yes, agents: _____

POA-HC activated ☐ No ☐ Yes, when: _____

Power of Attorney – Finances ☐ No ☐ Yes, agents: _____

Guardianship: ☐ No ☐ Yes, _____

Community Services and Assistance

☐ None	☐ Transportation	☐ Meals on Wheels	☐ Adult Day Services: _____
☐ Med-Alert	☐ Life Line	☐ Vial of Life	☐ Home Care: _____
☐ IRIS	☐ Family Care	☐ ADRC Assistance	☐ Home Health Care: _____
☐ Others:			

Phone screen completed by: _____ Date/time: _____

Patient Medical History

Patient name:_____ Date: _____

Person completing form:_____

Name Relationship Phone Number

Medications and Health Care Exams

Prescriptions (List current medications)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Non-Prescription (i.e., aspirin, laxatives, vitamins or minerals, if used regularly):

1. _____ 4. _____
2. _____ 5 _____
3. _____ 6 _____

Allergies (medication or food): ☐ None; if yes please list: _____

Pharmacy: _____ Phone number: _____

Prescription coverage: ☐ No ☐ Yes: _____ Date of last physical: _____

Date of last eye exam: _____ Date of last hearing exam: _____

Do you have a long-term care insurance plan? ☐ No ☐ Yes Are finances adequate? ☐ No ☐ Yes

Pain History and Current Pain Concerns

Have you experienced pain in the past? ☐ No ☐ Yes

If "yes", when did the pain occur? _____

Where did the pain occur? ☐ legs ☐ back ☐ hips ☐ knees ☐ arms ☐ shoulders ☐ other: _____

What treatment was effective to relieve the pain? ☐ relaxation ☐ whirlpool ☐ repositioning ☐ cold ☐ heat ☐ massage ☐ distraction ☐ other: _____

Describe the most intense pain you have ever experienced: _____

Are you currently in pain? ☐ No ☐ Yes

If "yes", rate the severity of your pain on a scale of one to ten (1 being least and 10 being highest level of pain):_____

Where do you currently have pain? ☐ legs ☐ back ☐ hips ☐ knees ☐ arms ☐ shoulders ☐ other: _____

What treatment(s) are you currently using to relieve the pain? ☐ relaxation ☐ whirlpool ☐ repositioning ☐ cold ☐ heat ☐ massage ☐ distraction ☐ other: _____

Medical History

Please check the appropriate boxes:

No	Yes		No	Yes	
☐	☐	High Blood Pressure	☐	☐	Urinary Tract Infection
☐	☐	Diabetes	☐	☐	Arthritis
☐	☐	Coronary Artery Disease	☐	☐	Osteoporosis
☐	☐	Respiratory (eg. Bronchitis, asthma)	☐	☐	Transient ischemic attacks (TIA's)
☐	☐	Hyperlipidemia/elevated cholesterol	☐	☐	Previous CVA/Stroke
☐	☐	Thyroid disorder	☐	☐	Seizure disorder
☐	☐	Renal (kidney) disease	☐	☐	Parkinson's Disease
☐	☐	Cancer (state kind):	☐	☐	Dementia
☐	☐	Eye (eg. Macular degeneration, glaucoma)	☐	☐	Depression
☐	☐	GERD (Gastric Reflux disease)	☐	☐	Anxiety
☐	☐	Head Injury	☐	☐	Tobacco use: _____ quantity
☐	☐	Prostate disease			
☐	☐	Urine or bowel incontinence	☐	☐	Alcohol use: _____ quantity

List surgeries & dates they occurred: _____

Please check box if you <u>currently</u> have a problem with any of the following symptoms. Describe yes responses:

Yes		Yes	
☐	Tremors: _____	☐	Pain or burning with urination:_____
☐	Frequent headaches: _____	☐	Difficulty starting or stopping urine:_____
☐	Blurred or double vision:_____	☐	Loss of urine with cough or sneeze:_____
☐	Ringing in the ears:_____	☐	Night time urination:_____
☐	Hearing loss:_____	☐	Blood in urine:_____
☐	Sinus problems:_____	☐	Recent chest pain/palpitations:_____
☐	Difficulty chewing or swallowing:_____	☐	Ankle swelling:_____
☐	Dizziness or lightheadedness:_____	☐	Increased cough:_____
☐	Occasional falls:_____	☐	Increased shortness of breath with activity:
☐	Muscle weakness:_____	☐	Loss of energy:_____
☐	Joint pain:_____	☐	Decreased appetite:_____
☐	Difficulty walking:_____	☐	Weight loss/ weight gain:_____
☐	Rash or skin problems:_____	☐	Heartburn:_____
☐	Breast lumps or tenderness:_____	☐	Sleep problems:_____
☐	Constipation or diarrhea:_____	☐	Memory loss:_____
☐	Blood in stool:_____	☐	Anxiety, nervousness:_____
		☐	Depression, sadness: _____
☐	Has eye glasses	☐	Has hearing aids
☐	Uses oxygen	☐	Has dentures, partials

Staff use only: Medical History reviewed by:_____ Date/Time:_____

Comments:

A sample instrument: Function

The following should be completed by a family member or friend. Check at **least one** box in each area. If patient needs help, please indicate who is providing the assistance next to that area. If it is an area that the person has limited to no experience over their life time, indicate that.

Dressing
- ☐ Is independent
- ☐ Has less interest in appearance
- ☐ Needs reminders to change clothes regularly
- ☐ Has problems putting on clothing correctly
- ☐ Needs total assistance with dressing

Bathing/Grooming
- ☐ Is independent, and is usually neatly groomed
- ☐ Has had a decline in hygiene
- ☐ Needs reminders to bathe / shower
- ☐ Needs help during bath / shower
- ☐ Sponges bathes (wash cloth, soap and water)

Circle equipment in home: bathing bench, grab bars, handheld shower

Continence
- ☐ Uses Depends, Poise Pads or Kotex Pads (independent)
- ☐ Uses Depends, Poise Pads or Kotex Pads (needs help)
- ☐ Uses the bathroom frequently
- ☐ Has accidents in bed at night

Toileting
- ☐ Is independent in using the bathroom
- ☐ Uses a commode
- ☐ Uses a raised toilet seat
- ☐ Needs help on and off the toilet
- ☐ Needs total assistance using the bathroom

Circle equipment in home: toilet grab bars, raised toilet seat commode

Eating/Feeding
- ☐ Is independent
- ☐ Doesn't use silverware, eats primarily finger foods
- ☐ Has problems with chewing and/or swallowing
- ☐ Forgets to eat, or forgets they have already eaten
- ☐ Has dentures, partials
- ☐ Needs help with eating

Walking/Transferring
- ☐ Walks independent
- ☐ Is unsteady when walking
- ☐ Hangs on to walls or furniture when walking
- ☐ Uses: cane walker wheelchair (circle item)
- ☐ Needs assistance to get up from chair
- ☐ Has fallen in the past 6 months

Medications
- ☐ Is independent
- ☐ Takes medications directly from prescription bottles
- ☐ Uses a pill planner for medications
- ☐ Needs a reminder to take medications
- ☐ Someone gives medications to patient
- ☐ Doesn't fill prescriptions on a regular basis

Adaptive Aids
- ☐ Has eye glasses
- ☐ Has hearing aids
- ☐ Has assistance with snow removal

Shopping
- ☐ Is independent
- ☐ Shops regularly online
- ☐ Repeats buying items
- ☐ Has problems checking out at the store
- ☐ Needs help when shopping out
- ☐ Someone else does the shopping

Food Preparation
- ☐ Is independent
- ☐ Has burned or forgotten items in oven /stove
- ☐ Has problems using the microwave
- ☐ Needs help with cooking
- ☐ Someone else does the cooking

Housekeeping,
- ☐ Is independent
- ☐ Has less interest in housekeeping tasks
- ☐ Home is less clean
- ☐ Needs help with housekeeping tasks
- ☐ Someone else cleans the home

Laundry
- ☐ Is independent with washing and drying clothes
- ☐ Rinses/washes clothes in the sink
- ☐ Wears dirty clothes
- ☐ Gets confused on how to operate the washer and/or dryer
- ☐ Needs help when doing the laundry
- ☐ Someone else does laundry

Telephone Use
- ☐ Is independent
- ☐ Repeats calling family and friends
- ☐ Has problems dialing out on the phone
- ☐ Has problems answering the phone
- ☐ Doesn't use the phone on a regular basis
- ☐ Has a cell phone

Finances
- ☐ Is independent
- ☐ Hides, loses, or misplaces money
- ☐ Has problems with cash transactions
- ☐ Has forgotten to pay bills, or is late in paying them
- ☐ Has been scammed or given valuable items away
- ☐ Needs assistance with writing out checks and paying bills
- ☐ Someone else handles all financial tasks

Transportation
- ☐ Is independent
- ☐ Gets lost
- ☐ Does not drive
- ☐ Never drove
- ☐ Uses a transportation service
- ☐ Had a car accident, car damage, or a ticket in past 6 months

Yard Work, House Maintenance
- ☐ Is independent
- ☐ Has assistance with yard work
- ☐ Has assistance with snow removal

Psychosocial History Supplement

Housing (Check all appropriate boxes)

Patient lives: ☐ by self ☐ with spouse/partner ☐ with family/other_____
name

Patient lives in:

☐ Single Story Home
☐ Condo
☐ Group Home (name): _____
☐ Skilled Nursing Facility (name): _____
☐ Two Story Home
☐ Independent. Apt. (name): _____
☐ Assisted Living Apt. (name): _____
☐ Other: _____

Length of time living at current housing: _____ Number of steps to get into home: _____

Are their working smoke alarms in the home? ☐ No ☐ Yes Are there guns or weapons in the home? ☐ No ☐ Yes

Background Information

Birth place: _____ Languages: ☐ English ☐ Other: _____

Ancestry and cultural influences: _____

Completed schooling through what grade: _____ List any learning disabilities: _____

Paid Employment

Retired: ☐ Yes, if so, when; _____ ☐ No, currently working at: _____

Employment history details: _____

_____

Military Experience

☐ No ☐ Yes, which branch and length of service: _____ Combat: ☐ Yes ☐ No

Volunteer Experiences _____

Major accomplishments and Honors: _____

Past hobbies and leisure interests (no longer does): _____

Current hobbies and leisure interests: _____

Spiritual involvement: ☐ Baptist ☐ Catholic ☐ Lutheran ☐ Methodist ☐ Presbyterian ☐ None/Other:_____

Family of Origin

Father's name: _____ Mother's name: _____

Number of sisters / brothers: _____ Number of sisters / brothers still living: _____

Family history of: Stroke ☐ No ☐ Yes Alcohol or drug concerns ☐ No ☐ Yes

Memory loss ☐ No ☐ Yes Mental health concerns ☐ No ☐ Yes

Marriage and Family

Current marital status: ☐ Single (never married) ☐ Married ☐ Widowed____ (year) ☐ Divorced_____ (year)

Spouse's name: _____ Years married:_____

If married more than once, please complete the item below:

Past spouse's Name:_____ Years married:_____ ☐ Widowed ☐ Divorced Year marriage ended:_____

Children (In birth order)	City/State They Reside In	Phone Number	Contact (staff use)
1.			
2.			
3.			
4.			

Other individuals involved / assisting: _____

Reviewed by:_____ Date/Time:_____