BROADWAY
FAMILY MEDICINE, INC.

STEADI SCREEN

Today's Date: _____

Patient Name: _____ DOB:_____

1.	One or more falls in the past year?	YES	NO
2.	Do you have trouble stepping up onto a curb?	YES	NO
3.	Have you been advised to use a cane or walker to get around safely?	YES	NO
4.	Do you have to rush to the toilet often?	YES	NO
5.	Do you feel unsteady when walking?	YES	NO
6.	Have you lost feeling in your feet?	YES	NO
7.	Do you steady yourself on furniture while walking at home?	YES	NO
8.	Do you take medication that makes you feel light headed or tired?	YES	NO
9.	Do you take medication for sleep or to improve your mood?	YES	NO
10.	Do you need to push with your hands when rising from a chair?	YES	NO
11.	Are you worried about falling?	YES	NO

X_____ Date: _____
Patient Signature

BROADWAY
FAMILY MEDICINE, INC.

HEALTH RISK ASSESSMENT FORM FOR WELLNESS VISITS **Today's Date**: _____

Patient Name: _____ DOB: _____

Do you need assistance to do any of the following:

Personal Care			***Household Chores***		
Bathing?	☐ Yes	☐ No	Laundry?	☐ Yes	☐ No
Dressing?	☐ Yes	☐ No	Shopping?	☐ Yes	☐ No
Grooming?	☐ Yes	☐ No	Cooking & Meal Prep?	☐ Yes	☐ No
Eating?	☐ Yes	☐ No	Housekeeping?	☐ Yes	☐ No
Using Toilet?	☐ Yes	☐ No	Money Management?	☐ Yes	☐ No
Taking your medications?	☐ Yes	☐ No			

Do you have problems with any of the following:

Walking/Do you require an assistance device?
- ☐ Yes ☐ No
- ☐ I have balance problems
- ☐ I use a cane
- ☐ I use a walker
- ☐ I use a wheelchair
- ☐ I use a power wheelchair or scooter

Do you have hearing problems?
- ☐ No
- ☐ Yes, right ear
- ☐ Yes, left ear
- ☐ Yes, both ears
- ☐ I wear hearing aids
- ☐ I am deaf

General questions affecting your health:

Do you follow a special diet?
- ☐ No
- ☐ Low salt/heart healthy diet
- ☐ Diabetic diet
- ☐ Low cholesterol diet
- ☐ Weight loss diet
- ☐ Weight gain diet

How good are you at taking your medications as prescribed?
- ☐ Excellent – All of the time
- ☐ Good – Most of the time
- ☐ Poor – Skip a lot
- ☐ I am not taking my prescribed medications

How would you rate your current exercise habits?
- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ I don't exercise at all

Primary mode of transportation?
- ☐ Ambulance
- ☐ Ambulette
- ☐ Car service
- ☐ Metro train
- ☐ Personal car
- ☐ Privately arranged
- ☐ Public bus
- ☐ Public transportation
- ☐ Ride with friend or family
- ☐ Taxi service

Advance Directives (check all that apply)
- ☐ I have a living will
- ☐ I have a Durable Power of Attorney for Healthcare
- ☐ I want to discuss my end of life wishes

Have you had any concerns about your memory?
- ☐ Yes
- ☐ No

Have your family or friends had any concerns about your memory?
- ☐ Yes
- ☐ No

Are you currently having issues with pain that you would like to address at today's visit?
- ☐ Yes
- ☐ No

Patient Name: _____ **DOB:** _____

Today's Date: _____

Socioeconomic (Demographics) ***Please circle your answers.**

- Years of Education _____
  What is the highest level of school you have completed or the highest degree you have earned? _____
- Financial Resource Strain
  How hard is it for you to pay for the very basics like food, housing, medical care, and heating?
  Not hard at all Not very hard somewhat hard Hard Very hard Decline
- Food Insecurity
  Within the past 12 months you worried that your food would run out before your money to buy more.
  Never true Sometimes true Often true Decline
  Within the past 12 months the food you bought just didn't last and you didn't have money to get more.
  Never true Sometimes true Often true Decline
- Transportation Needs
  In the past 12 months has lack of transportation kept you from your medical appointments or from getting medications? Yes No Decline
  In the past 12 months has lack of transportation kept you from meetings, work or getting things needed for daily living? Yes No Decline
- Lifestyle
  On average, how many days per week do you engage in moderate to strenuous exercise (like walking fast, running, jogging, dancing, swimming, biking, or other activities that cause a light or heavy sweat)?
  0 days 1 day 2days 3 days 4 days 5 days 6 days 7 days Decline
  On average, how many minutes do you engage in exercise at this level?
  0 min 10 min 20 min 30 min 40 min 50 min 60 min 70 min 80 min 90 min
  100 min 110 min 120 min
- Stress
  Do you feel stressed, tense, restless, nervous, or anxious, or unable to sleep at night because your mind is troubled all the time these days?
  Not at all Only a little To some extent Rather much Very much Decline

Relationships (Social Connections)

- In a typical week how many times do you talk on the phone with family, friends or neighbors?
  Never Once a week Twice a week 3x a week More than 3x a week Decline
- How often do you get together with friends or relatives?
  Never Once a week Twice a week 3x a week More than 3x a week Decline
- How often do you attend church or religious services?
  Never 1 to 4 times per year More than 4 times Decline
- Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups? Yes No Decline
- How often do you attend meetings of the clubs or organization you belong to?
  Never 1-4 times per year More than 4 times Decline
- Are you now married, widowed, divorced, separated, never married or living with a partner?
  Married Widowed Divorced Never married Living with partner Decline
- Within the last year, have you been afraid of your partner or ex-partner? Yes No Decline
- Within the last year, have you been humiliated or emotionally abused in other ways by your partner or ex-partner? Yes No Decline
- Within the last year, have you been kicked, hit, slapped, or otherwise physically hurt by your partner or ex-partner? Yes No Decline
- Within the last year, have you been raped or forced to have any kind of sexual activity by your partner or ex-partner? Yes No Decline