Health Questionnaire for Adults

Please fill out this questionnaire to the best of your ability or have a caregiver or family member assist you in filling it out.

Please reflect on your health over the past **1 month** and check the box that best fits you.

	Yes	Sometimes	No
Do you have any concerns regarding your memory or ability to understand things as you have gotten older? If yes, what concerns do you have? _____ _____			
Have you been feeling down or depressed recently?			
Have you been feeling anxious recently?			
Have you been feeling more fatigued?			
Do you see or hear things/people/shapes that other people may not see or hear?			
Do you feel other people are trying to harm you?			
Do you feel people are stealing from you?			
Do you feel more suspicious of people around you?			
Do you feel motivated?			
Is your health good?			
Do you have trouble speaking?			
Do you have a hard time hearing?			
Do you have a hard time seeing?			
Are you weak in your arms?			
Are you weak in your legs?			
Do you exercise? If yes, what exercises do you do/how often in a week?_____ _____			
Do you feel off-balance?			
Have you had falls recently? If yes, what happened/happens? _____ _____			
Is your appetite good?			
Do you have control of your urine?			
Do you use a urinary catheter?			
Do you have control of your bowels?			

Do you have constipation? (e.g no daily soft bowel movement)			
Do you have good sleep?			
Do you feel drowsy during the day?			
Do you feel your sleep is disrupted?			
Do you have a hard time getting to sleep?			
Do you regularly socialize with friends/family?			

Activities:

Check the box that best fits you for these activities.

	Yes	**Yes, but need help**	**No**
Can you walk outside or an unfamiliar place by yourself?			
Can you walk inside your house by yourself?			
Can you move from one position to the next by yourself? (e.g get up from a chair)			
Can you get onto a bed by yourself?			
Do you use anything to help you walk or get around? If yes, what do you use?_____			
Do you feed yourself?			
Do you bathe yourself?			
Do you dress yourself?			
Do you use the toilet by yourself?			
Do you cook your own food?			
Do you clean up by yourself?			
Do you shop by yourself?			
Do you take your medications by yourself?			
Do you drive by yourself?			
Do you do your banking by yourself?			
Do you pay your bills by yourself?			

Circle one:

I am… Married Divorced Widowed Single

I live… Alone With a significant other (spouse/partner) With someone else

I live in… An apartment/house An assisted living A nursing home

If you live in a house….

How many levels in the house? _____

How many steps/stairs to get into the house?_____

Circle all that apply:

I have… Informal support A paid caregiver Home nursing care Other:_____

If you have a caregiver, what is their relationship to you? _____
Is your caregiver feeling stressed? _____

Circle one:

Do you have an advanced directive or will? Yes No

If you were to pass away, would you want doctors to try to bring you back to life using CPR (chest compressions and electricity)? Yes Yes, with limits No

If you circled **yes, with limits**, what limits would you want? _____
_____