# F R A N K L I N  C L I N I C

FALL RISK ASSESSMENT

**Patient: _____ DOB: _____**
**Provider: _____ DATE: _____**

| QUESTIONS: | Y | N | SCORE |
|---|---|---|---|
| Do you have a history of falling? | 1 | 0 | |
| Do you experience dizziness &/or have trouble keeping your balance? | 1 | 0 | |
| Is walking difficult due to muscle weakness, stiff joints, or foot problems? | 1 | 0 | |
| Are you on more than 3 medications? | 1 | 0 | |
| Do you have problems with your vision? | 1 | 0 | |
| Do you make frequent or hurried trips to the bathroom? | 1 | 0 | |
| Have you put off dealing with household hazards, such as poor lighting, slippery floors, throw rugs, grab-bars, etc? | 1 | 0 | |
| Is fear of falling making you less physically active & reducing your social activity? | 1 | 0 | |
| Are you experiencing problems with concentration, depression, or isolation? | 1 | 0 | |
| Do you consume alcohol more than occasionally? | 1 | 0 | |
| If you were to fall, would you be alone & possibly unable to summon help? | 1 | 0 | |
| TOTAL RISK POINTS | | | |

(www.lifeline.ca)

# F R A N K L I N  C L I N I C

**Patient: _____ DOB: _____**
**Provider: _____ DATE: _____**

| FUNCTIONAL ABILITIES / ACTIVITIES OF DAILY LIVING | | SCORE |
|---|---|---|
| **BOWELS:** | 0 = Incontinent or constipated (requiring enemata)<br>1 = Occasional accident (once a week)<br>2 = Continent | |
| **BLADDER:** | 0 = Incontinent or catheterized & unable to manage<br>1 = Occasional accident (max. one per 24 hours)<br>2 = Continent (for over 7 days) | |
| **GROOMING:** | 0 = Needs help with personal care<br>1 = Independent with face/hair/teeth/shaving (implements providing) | |
| **TOILET USE:** | 0 = Dependent<br>1 = Needs some help but can do some things alone<br>2 = Independent (on & off, dressing, wiping) | |
| **FEEDING:** | 0 = Unable<br>1 = Needs help cutting, cutting spreading butter, etc.<br>2 = Independent ( food provided within reach) | |
| **TRANSFER:** | 0 = Unable ( no sitting balance)<br>1 = Major help (1-2 people, physical) can sit<br>2 = Minor help (verbal or physical)<br>3 = Independent (may use any aid) | |
| **MOBILITY:** | 0 = Immobile<br>1 = Wheelchair independent, including corners, etc.<br>2 = Walks with help of 1 person (verbal or physical)<br>3 = Independent (may use any aid) | |
| **DRESSING:** | 0 = Dependent<br>1 = Needs help but can do about half unaided<br>2 = Independent ( including buttons, zips, laces, etc.) | |
| **STAIRS:** | 0 = Unable<br>1 = Needs help (verbal, physical, carrying aid)<br>2 = Independent up & down | |
| **BATHING:** | 0 = Dependent<br>1 = Independent (or in shower) | |
| **SCORING:**<br>☐ **Significant risk for falls (Check if mobility score <=2, transfer score <=2, &/or stairs score <=1**<br>☐ **Assess for supervised care (check if total is <=15)** | | **_TOTAL_** |

# F R A N K L I N  C L I N I C

DEPRESSION SCREENING

**Patient: _____ DOB: _____**
**Provider: _____ DATE: _____**

**Over the last 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 EVERY DAY |
|---|---|---|---|---|
| Little interest or pleasure in doing things | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| Feeling down, depressed, or hopeless | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| Trouble falling or staying asleep, or sleeping too much | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| Feeling tired or having little energy | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| Poor appetite or overeating | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| Feeling bad about yourself or that you are a failure or have let yourself or your family down | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| Trouble concentrating on things, such as reading the newspaper or watching television | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| 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 ☐ |
| Thoughts that you would be better off dead, or of hurting yourself | 0 ☐ | 1 ☐ | 2 ☐ | 3 ☐ |
| ADD COLUMNS | | + | | + |
| TOTAL | | | | |

| If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | NOT DIFFICULT | SOMEWHAT DIFFICULT | VERY DIFFICULT | EXTREMELY DIFFICULT |
|---|---|---|---|---|

(PHQ-9)

# F R A N K L I N  C L I N I C

ALCOHOL BEHAVIOR SCREENING

**Patient: _____ DOB: _____**

**Insurance: _____ DATE: _____**

| | |
|---|---|
| 1. How often do you have a drink containing alcohol?<br>**(0)** Never *(Skip to Questions 9-10)* **(1)** Monthly or less **(2)** 2 to 4 times a month<br>**(3)** 2 to 3 times a week **(4)** 4 or more times a week | SELECT |
| 2. How many drinks containing alcohol do you have on a typical day when you are drinking?<br>**(0)** 1 or 2 **(1)** 3 or 4 **(2)** 5 or 6 **(3)** 7, 8, or 9 **(4)** 10 or more | SELECT |
| 3. How often do you have six or more drinks on one occasion?<br>**(0)** Never **(1)** Less than monthly **(2)** Monthly **(3)** Weekly **(4)** Daily or almost daily | SELECT |
| 4. How often during the last year have you found that you were not able to stop drinking once you had started?<br>**(0)** Never **(1)** Less than monthly **(2)** Monthly **(3)** Weekly **(4)** Daily or almost daily | SELECT |
| 5. How often during the last year have you failed to do what was normally expected from you because of drinking?<br>**(0)** Never **(1)** Less than monthly **(2)** Monthly **(3)** Weekly **(4)** Daily or almost daily | SELECT |
| 6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?<br>**(0)** Never **(1)** Less than monthly **(2)** Monthly **(3)** Weekly **(4)** Daily or almost daily | SELECT |
| 7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?<br>**(0)**Never **(1)** Less than monthly **(2)** Monthly **(3)** Weekly **(4)** Daily or almost daily | SELECT |
| 8. How often during the last year have you had a feeling of guilt or remorse after drinking?<br>**(0)** Never **(1)** Less than monthly **(2)** Monthly **(3)** Weekly **(4)** Daily or almost daily | SELECT |
| 9. Have you or someone else been injured as a result of your drinking?<br>**(0)** No **(2)** Yes, but not in the last year **(4)** Yes, during the last year | SELECT |
| 10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?<br>**(0)** No **(2)** Yes, but not in the last year **(4)** Yes, during the last year | SELECT |

| **SCORE** |
|---|
| |

Alcohol Use Disorders Identification Test (AUDIT)

Franklin Clinic

# PATIENT SURVEY

DOB:_____
NAME: _____DATE: _____

Please indicate below if you have any of the following symptoms:

- ☐ Bulging or varicose veins, spider veins
- ☐ Discolored or darkened skin on legs
- ☐ Aching, cramping, swelling or restlessness in legs
- ☐ Difficulty sleeping at night due to leg discomfort
- ☐ Non-healing or recurrent sore on legs or ankles

---

- ☐ Known hemorrhoids, painful bowel movement, rectal discomfort
- ☐ Blood on toilet paper, on stool, or in toilet after bowel movement

---

- ☐ Skin spots that are changing in size, color, shape, feel
- ☐ Scaling, flaking, or crusted skin lesions
- ☐ Skin spots that itch or often bleed

---

- ☐ Joint pain that worsens with increased activity
- ☐ Cracking, popping, or crunching sound with movement of a joint
- ☐ Recurrent swelling or warmth of a joint, particularly with overuse
- ☐ Restricted range of motion of a joint

If you have any of the above symptoms you may have venous disease, hemorrhoids, benign or malignant skin lesions, or osteoarthritis. Speak with your provider today about options for treatment or further evaluation.