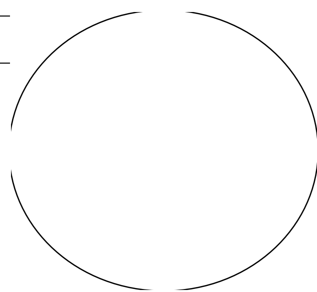
End of Life Care	
Do you have an Advanced Directive or Living Will?	____Yes ____No
Name/phone # of health care proxy/ surrogate_______________________________________	
Do you wish to discuss any end-of-life issues during this visit?	____Yes ____No
__Depression Screen : Do you feel down or depressed?	___ Yes ____No
Activities of Daily Living	
Do you need assistance with activities of daily living, such as dressing, grooming, toileting, feeding?	
If yes:____	
Do you need assistance with activities such as banking, managing appointments, cooking, shopping?	
If yes: ____	
Safety Screening	
Do you feel you have any significant safety concerns?	___Yes ___No
Do you have any trouble seeing, hearing, or speaking?	___Yes ___No
Do you have any trouble bathing, dressing, or eating?	___Yes ___No
Do you feel unstable or unsteady when standing?	___Yes ___No
Do you have any trouble using stairs, if you have them?	___Yes ___No
Have you fallen or almost fallen in the last 60 days?	___Yes ___No
Do you know of any hazards in your home?	___Yes ___No
Would you have any trouble getting 911 help if needed?	___Yes ___No
Cognition Screening	

Pretend the circle is a clock.

1. Write the numbers on the clock.
2. Mark the time as "11:10"



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