(Patient Label / Addressograph)

New Patient Questionnaire

(To be Completed by Patient)

Date: **Time:**

NUTRITION RISK SCREEN:	**Yes**
Circle the number in the "Yes" column for those that apply and total nutrition score at bottom. (Interventions are documented by Case Manager in the Care Plan.)	
I have an illness or condition that made me change the kind and/or amount of food I eat	2
I eat fewer than two meals per day	3
I eat few fruits and vegetables, or milk products	2
I have three or more drinks of beer, liquor or wine almost every day	2
I have tooth or mouth problems that make it hard for me to eat	2
I don't always have enough money to buy the food I need	4
I eat alone most of the time	1
I take three or more different prescribed or over-the-counter drugs a day	1
Without wanting to, I have lost or gained 10 pounds in the last six months	2
I am not always physically able to shop, cook and/or feed myself	2
This DETERMINE Health Screening Checklist was developed and distributed by the: Nutritional Screening Initiative, a project of: American Academy of Family Physicians, The American Dietetic Association, National Council on the Aging, Inc.; Retrieved on line January 2019 **Total Score:**	

0 - 2 = Good Risk	**3 - 5 = Moderate Risk**	**6 or Higher = High Risk**
• No interventions needed	• Provide education on nutrition • Provide education on elevated blood sugars and impact on wound healing, as applicable	• Provide education on nutrition • Provide education on elevated blood sugars and impact on wound healing, as applicable • Obtain provider order for referral of patient for further nutrition evaluation

ABUSE/SUICIDE RISK SCREEN: *Check the appropriate answer for each question.*		
(Interventions are documented by Case Manager in the Care Plan.)		
1. Has anyone close to you tried to hurt or harm you recently?	☐ Yes	☐ No
2. Do you feel uncomfortable with anyone in your family?	☐ Yes	☐ No
3. Has anyone forced you to do things that you didn't want to do?	☐ Yes	☐ No
4. Do you have any thoughts of harming yourself?	☐ Yes	☐ No

If yes to any of the above questions, explain: _____

FALLS RISK SCREEN: *Circle the appropriate score for each question. Total the score at the bottom of this section.*		**Yes**
(Interventions are documented by Case Manager in the Care Plan.)		
1. History of falling - immediate or within 3 months		25
2. Secondary diagnosis *(Do you have 2 or more medical diagnoses?)*		15
3. Ambulatory aid	*None / bed rest / nurse* assist	0
	Crutches / cane / walker	15
	Furniture	30
4. Intravenous therapy Access / Saline / Heparin Lock		20
5. Gait / Transferring	*Normal / bed rest / wheelchair*	0
	Weak (short steps with or without shuffle, stooped but able to lift head while walking, may seek support from furniture)	10
	Impaired (short steps with shuffle, may have difficulty arising from chair, head down, impaired balance)	20
6. Mental status	*Oriented to own ability*	0
	Overestimates or forgets limitations	15
Agency for Healthcare Research and Quality National Center for Patient Safety. Morse Fall Scale; Retrieved online January 2019 http://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3h.html **Total Score:**		

Fall Risk Scale and Risk Level

0 – 24 = Low Risk **25 – 50 = Medium Risk** **51 and higher = High Risk**

Patient Signature: _____ **Date:** _____ **Time:** _____

Reviewed by Case Manager Signature: _____ **Date:** _____ **Time:** _____

PAP Form-18 • Rev 04/19
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New Patient Questionnaire
(Page 2)

D **Time:**

PAIN *(Interventions are documented by Case Manager in the Care Plan.)*

Pain present now? ☐ Yes ☐ No - If **NO**, skip rest of this section.

With Dressing Changes: ☐ Yes ☐ No **Location of Pain:**

Current Pain Level: ☐ Unable to feel pain 0 1 2 3 4 5 6 7 8 9 10 **Duration of Pain:** ☐ Constant ☐ Intermittent

Character of Pain: ☐ Aching ☐ Burning ☐ Cramping ☐ Difficult to Pinpoint ☐ Dull ☐ Easy to Pinpoint ☐ Exhausting ☐ Heavy ☐ Sharp ☐ Shooting ☐ Splitting ☐ Stabbing ☐ Tender ☐ Throbbing ☐ Tiring ☐ Other:

Pain Management: *My pain is relieved by:* ☐ Medication ☐ Rest ☐ Activity ☐ Heat Application ☐ Cold Application ☐ Massage ☐ T.E.N.S. ☐ Leg Drop or Elevation ☐ Other:

What is your Pain Management Goal? *(Provide a pain level number between 1-10)*

Is Current Pain Management Adequate? ☐ Adequate ☐ Inadequate

WOUND IMPACT ON ACTIVITIES OF DAILY LIVING

Does your wound impact the following activities:

Dressing/Bathing:	☐ Yes	☐ No	**Hygiene:**	☐ Yes	☐ No	**Housekeeping:**	☐ Yes	☐ No
Eating:	☐ Yes	☐ No	**Ability to use phone:**	☐ Yes	☐ No	**Laundry:**	☐ Yes	☐ No
Ambulating:	☐ Yes	☐ No	**Shopping:**	☐ Yes	☐ No	**Handle medications:**	☐ Yes	☐ No
Toileting:	☐ Yes	☐ No	**Food Preparation:**	☐ Yes	☐ No	**Handle money:**	☐ Yes	☐ No

EDUCATION *(Interventions are documented by Case Manager in the Care Plan.)*

Who will receive education on patient's wound or condition?

☐ Patient **OR**

☐ Caregiver – Name of Caregiver: _____

Learning preferences below are of the individual noted above.

Learning Preference: ☐ Explanation ☐ Demonstration ☐ Video ☐ Communication Board ☐ Printed Material

Highest Education Level: ☐ College or Above ☐ High School ☐ Grade School

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Preferred Language for Healthcare Information: ☐ English ☐ Spanish ☐ Other:

Translator Needed? ☐ No ☐ Yes

Are there Cultural/Religious Beliefs that would impact wound care - e.g. use of blood, porcine (pig) or bovine (cow) based tissue products: ☐ No ☐ Yes

If Yes, please explain:

Impaired Vision: ☐ No ☐ Glasses ☐ Contacts ☐ Legally Blind **Impaired Hearing:** ☐ No ☐ Complete Loss ☐ Hearing Aid

Do you have problems with your hands that limit your ability to grip or pull? ☐ Yes ☐ No

What is your knowledge Level regarding your wound? ☐ High ☐ Medium ☐ Low

What is your ability to understand written instructions? ☐ High ☐ Medium ☐ Low

What is your ability to understand verbal instructions? ☐ High ☐ Medium ☐ Low

SELF HEALTH MANAGEMENT *(Interventions are documented by Case Manager in the Care Plan.)*

Are you willing to engage in self-management activities? ☐ Yes ☐ No

Are you ready to engage in self-management activities? ☐ Yes ☐ No

Other: Do you smoke tobacco or other substances? ☐ Yes ☐ No **Are you diabetic?** ☐ Yes ☐ No

NURSE'S NOTES

Patient Signature: _____ **Date:** _____ **Time:** _____

Reviewed by Case Manager Signature: _____ **Date:** _____ **Time:** _____