Louisiana Healthcare Associates, LLC

Wellness Assessment

Patient Name: _____ **Date:** _____
Last Name, First Name

Do you use any form of tobacco? Yes ☐ No ☐

If yes, please indicate what type: Cigarettes Cigar Pipe Chewing Smokeless Snuff E-Cigarettes

Do you drink alcohol? Yes ☐ No ☐

Please select one: Daily Weekly Monthly Occasionally Rarely Socially

What was the date of your last Influenza shot? _____

What was the date of your last Pneumonia Shot? _____

Have you had any falls in the past year? Yes ☐ No ☐

If yes, how many? _____

On a scale of 0-10, how do you rate your pain level today? _____

Do you experience little interest or pleasure in doing things? Yes ☐ No ☐

If yes, please select one: Several days a month More than half the days a month Nearly everyday

Are you feeling down, depressed or hopeless? Yes ☐ No ☐

If yes, please select one: Several days a month More than half the days a month Nearly everyday