Patient Name: ______________________

Depression Screening

Over the last two weeks, how often have you been bothered by any of the following? Circle One.				
	Not at all	Several Days	More than half the day(s)	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 badly 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 fidgety or restless so 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 in some way.	0	1	2	3

If you circled any problems above, how difficult have these problems made it for you to do your work, take care of things, and get along with other people? Circle one.

Not Difficult
Somewhat Difficult
Very Difficult
Extremely Difficult

Office Use Only

PHQ Total Score ___________

Patient Name: ______________________

Fall Screening

Please answer the following questions (check Yes or No):	Yes	No
Have you had two or more falls in the past year?		
Have you had any fall that resulted in an injury in the past year?		
Do you have difficulty with walking or balance?		
If you answered YES to the previous question, do you use a cane, walker or wheelchair?		
Do you have uncorrected vision problems such as glaucoma or cataracts?		

****

Office Use Only

	Yes	No
Is the patient identified for “Risk of Falls?”		
Was the patient given educational information on Falls?		
Is the patient wheelchair bound?		
Does the patient present with an acute fall?		