ARIA
Healing from Within

FOR OUR VALUED MEDICARE PATIENTS

Medicare offers Medicare beneficiaries a free “Welcome to Medicare Exam” and subsequent “Annual Wellness Visits” where you and your health care provider will have extra time to make a personalized prevention plan to keep you healthy in the future. At a wellness visit you will receive:

- A personalized plan and counseling about preventive services, including recommended health screenings, immunizations and referrals for other care that you may need.
- A review of your medical, surgical and family history
- Height, weight, body mass index and blood pressure measurements
- A vision and hearing screening
- A review of your potential risk for depression
- A personal safety and fall assessment
- A discussion about creating or updating healthcare power of attorney and advanced directives
- Medication review

Medicare waives co-payments for these visits and for many preventative tests ordered during the visit as long as the visit does NOT include any discussion about new or current medical problems or conditions. If you prefer at the time of your visit to instead discuss any new or current medical problems, please let our staff know of your wishes so that your Annual Wellness Visit can be rescheduled to a later date to allow time for your health care provider to address your more pressing health concerns. Please note that if any new or current medical problems are discussed with your health care provider, then our office will charge the usual Medicare fees for services, including co-pays.

Please note that the Annual Wellness Visit is not the same thing as what many people often refer to as the yearly physical exam, which is a hands-on exam and is not covered by Medicare.

We appreciate the trust you put in us to take care of your health care needs and hope that you will take advantage of this opportunity to work with your physician in creating your personalized prevention plan.

Please complete the attached documents and bring with you to your appointment.

ARIA
Healing from Within

Medicare Wellness Annual Visit Health Risk Assessment

Name: _____ Date: _____ Date of Birth: _____

Please complete this checklist before seeing your provider. Your responses will help you receive the best health care possible.

1. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

2. During the past 4 weeks, has your physical and emotional health limited your social activities with family, friends, neighbors or groups?
   - ☐ Not at all
   - ☐ Slightly
   - ☐ Moderately
   - ☐ Quite a bit
   - ☐ Extremely

3. During the past 4 weeks, how much bodily pain have you generally had?
   - ☐ No pain
   - ☐ Very mild pain
   - ☐ Mild pain
   - ☐ Moderate pain
   - ☐ Severe pain

4. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.
   - ☐ Yes, as much as I wanted
   - ☐ Yes, quite a bit
   - ☐ Yes, some
   - ☐ Yes, a little
   - ☐ No, not at all

5. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?
   - ☐ Very heavy
   - ☐ Heavy
   - ☐ Moderate
   - ☐ Light
   - ☐ Very light

	Yes	No
6. Can you get places out of walking distance without help? For example, can you travel alone by bus, taxi, or drive your own car?	☐	☐
7. Can you shop for groceries or clothes without help?	☐	☐
8. Can you prepare your own meals?	☐	☐
9. Can you do your own housework without help?	☐	☐
10. Can you handle your own money without help?	☐	☐
11. Do you need help eating, bathing, dressing, or getting around your home?	☐	☐

12. During the past 4 weeks, how would you rate your health in general?
   - ☐ Excellent
   - ☐ Very good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

13. How have things been going for you during the past 4 weeks?
   - ☐ Very well – could hardly be better
   - ☐ Pretty good
   - ☐ Good and bad parts about equal
   - ☐ Pretty bad
   - ☐ Very bad – could hardly be worse

14. Are you having difficulties driving your car?
☐ Yes, often
☐ Sometimes
☐ No
☐ Not applicable

15. Do you always fasten your seat belt when you are in a car?
☐ Yes, usually ☐ Yes, sometimes ☐ No

16. How often during the <u>past 4 weeks</u> have you been <u>bothered</u> by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Fall or dizzy when standing up	☐	☐	☐	☐	☐
Sexual problems	☐	☐	☐	☐	☐
Trouble eating well	☐	☐	☐	☐	☐
Teeth or dentures	☐	☐	☐	☐	☐
Problems using the telephone	☐	☐	☐	☐	☐
Tired or fatigued	☐	☐	☐	☐	☐

17. Have you fallen 2 or more times in the past year?
☐ Yes ☐ No

18. Are you afraid of falling?
☐ Yes ☐ No

19. Have you ever used tobacco?
☐ No
☐ Yes

20. Do you take prescription or over-the-counter medications for pain relief?
☐ Yes
☐ No

21. Do you get physical activity for about 20 minutes a day for 3 or more days a week?
☐ Yes, most of the time
☐ Yes, some of the time
☐ No

22. Are you worried about your memory?
☐ Yes ☐ No

23. How often do you have trouble taking medicines the way you have been told to take them?
☐ I do not have to take medicine
☐ I always take them as prescribed
☐ Sometimes I take them as prescribed
☐ I seldom take them as prescribed

24. How confident are you that you can control and manage most of your health problems?
☐ Very confident
☐ Somewhat confident
☐ Not very confident
☐ I do not have any health problems

25. Have any of your close relatives had any health changes?
☐ Yes ☐ No

26. Have you recently had any preventive tests, such as lab tests, mammogram, or colonoscopy?
☐ Yes ☐ No

27. Have you had any recent immunizations?
☐ Yes ☐ No

28. Do you have a living will or advance directive?
☐ Yes *(please bring a copy of it with you to your next visit)*
☐ No

ARIA
Healing from Within

PHYSICIANS & MEDICATIONS

Please write the names of all your doctors:

Name	Specialty

Please write the names of all your medications, including vitamins and supplements (or bring in all pill bottles to your appointment):

Name of Medicine	Dose

AriaMed
10 Harris Court, Suite A
Monterey, CA 93940

Ph: 831.900.5115
Fax: 844.560.2476
ariamed.org

PATIENT HEALTH QUESTIONNAIRE-2 (PHQ-2)

Instructions: Please respond to each question.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Give answers as 0 to 3, using this scale:

- 0 = Not at all
- 1 = Several days
- 2 = More than half the days
- 3 = Nearly every day

1. Little interest or pleasure in doing things

☐ 0 ☐ 1 ☐ 2 ☐ 3

2. Feeling down, depressed, or hopeless

☐ 0 ☐ 1 ☐ 2 ☐ 3

Total Score: _____

AriaMed
10 Harris Court, Suite A
Monterey, CA 93940

Ph: 831.900.5115
Fax: 844.560.2476
ariamed.org

AUDIT-C Questionnaire

Patient Name _____ Date of Visit _____

Date of Birth _____

1. **How often do you have a drink containing alcohol?**
   - ☐ Never
   - ☐ Monthly or less
   - ☐ 2-4 times a month
   - ☐ 2-3 times a week
   - ☐ 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ 1 or 2
   - ☐ 3 or 4
   - ☐ 5 or 6
   - ☐ 7 to 9
   - ☐ 10 or more

3. **How often do you have six or more drinks on one occasion?**
   - ☐ Never
   - ☐ Less than monthly
   - ☐ Monthly
   - ☐ Weekly
   - ☐ Daily or almost daily

Remaining AUDIT Questions

Questions	Scoring System					Your Score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the lsat year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor, or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 -15 Increasing risk,
16 – 19 Higher Risk, 20+ Possible dependence

TOTAL AUDIT Score: _____

(AUDIT-C Score (above) + Score of remaining questions)

831.900.5115
10 Harris Court, Suite A, Monterey, CA 93940
515 Alameda Avenue, Suite D, Salinas, CA 93901