Clever Care HEALTH PLAN

Annual Wellness Assessment

Patient Name _____ **Date of Service** / /

Date of Birth / / **Patient ID** _____

PLEASE RETAIN A COPY FOR YOUR RECORDS

PERSONAL HISTORY: Have you experienced any of the following in the last year? ***(Check any that apply)***

Constitutional	Gastrointestinal	Pulmonary	Musculoskeletal
☐ Sweating	☐ Reflux	☐ Cough	☐ Joint pain
☐ Fatigue/Tired	☐ Black stool	☐ Blood in sputum	☐ Muscle pain
☐ Fever	☐ Blood in stool	☐ Shortness of breath	☐ Past fractures
☐ Weight loss	☐ Nausea	☐ Use oxygen	☐ Muscular weakness
☐ Weight gain	☐ Vomiting	☐ Hard to breathe	☐ Swelling
Eye/Ear/Nose/Throat	**Neurological**	**Skin**	**Endocrine**
☐ Vision changes	☐ Headaches	☐ Rash	☐ Excessive thirst
☐ Blurry vision	☐ Tingling sensation	☐ Dryness	☐ Cold/heat intolerance
☐ Difficulty swallowing	☐ Numbness	☐ Itching	☐ Change in appetite
☐ Hearing loss	☐ Seizure activity	☐ Discoloration	☐ Weight loss
☐ Ringing in the ears	☐ Dizziness	☐ Hair loss	☐ Weight gain
Genitourinary	**Pain**	**Other**	
☐ Frequent urination	☐ Knee pain	☐ Fainting/black out	☐ Anxiety
☐ Blood in urine	☐ Hip pain	☐ Dizziness	☐ Loss of balance
☐ Pain while urinating	☐ Shoulder pain	☐ Extreme tiredness	☐ Confusion
☐ Rash in genital area	☐ Back pain	☐ Forgetfulness	☐ Excessive sleeping
☐ Discharge	☐ Heart/chest pain	☐ Sad/depression	☐ Vertigo

FAMILY HISTORY: Please indicate if any person, related by blood, had any of the following conditions.

☐ Adopted—I know my family history ☐ Adopted—I do NOT know my family history

Condition	Relationship	Condition	Relationship
Hypertension		Glaucoma	
Stroke		Cancer	
Heart Disease		Alcoholism	
High Cholesterol		Asthma/COPD	
Diabetes		Depression/Suicide	
Chronic Kidney Disease		COVID	

Any other concerns about your health? _____

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VITAL SIGNS

HEIGHT		WEIGHT		BMI		BP		PULSE OX.	

SOCIAL HISTORY: Please answer all questions

1) Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

2) Does patient currently chew or snuff tobacco? ☐ Yes ☐ No **(1035F)**

3) Does patient currently smoke tobacco? ☐ Yes **(1034F)** ☐ No **(1036F)**

a. If yes, how many packs a day? _____

b. For how many years? _____

4) Does patient consume alcoholic beverages? (G0442) ☐ Yes ☐ No

a. Does patient have four or more drinks in a day? ☐ Yes ☐ No

5) Does patient use recreational drugs? ☐ Yes ☐ No

a. If yes, how often? _____

PATIENT HEALTH QUESTIONNAIRE (3725F): Select answers that apply to your current situation

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

PHQ-9 Questions / *Frequency*	*Not at all*	*Several days*	*More than half the days*	*Nearly everyday*
1) Little interest or pleasure in doing things	0	1	2	3
2) Feeling down, depressed, or hopeless	0	1	2	3
3) Trouble falling or staying asleep, or sleeping to much	0	1	2	3
4) Feeling tired or having little energy	0	1	2	3
5) Poor appetite or overeating	0	1	2	3
6) Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7) Trouble concentrating on things, such as reading he newspaper or watching television	0	1	2	3
8) Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9) Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add columns	_____	_____	_____	_____

TOTAL (score will be calculated by medical professional) _____

If you checked off *any* problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ **Not difficult at all** ☐ **Very difficult**

☐ **Somewhat difficult** ☐ **Extremely difficult**

Healthcare professional: for interpretation of the TOTAL, please refer to PHQ-9 scoring and card severity determination.

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PHYSICAL ASSESSMENT: Complete patient's physical assessment and document if there are abnormal findings

	Within Normal Limits (☑)	Abnormal Findings (if any)
General Appearance		
HEENT		
Cardiovascular		
Respiratory		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Neurological		
Lymphatic		
Skin		
Psychiatric		
Other		

OTHER MEDICAL CARE: List all physicians or suppliers who provided medical care to the patient

Physician Name	Date	Condition	Physician Name	Date	Condition

PAIN ASSESSMENT (1125F or 1126F): Assess patient's level of pain, if present.

0	1	2	3	4	5	6	7	8	9	10
No pain (1126F)	Pain present (1125F)									
Location of pain, if pain is present:										

MEDICATION LIST AND REVIEW (1159F and 1160F): List patient's medications and review the list

Current Medications

Allergies or Reaction to Medication:

_____

_____

_____

☐ **Medication list has been reviewed and reconciled (1160F)**

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FUNCTIONAL STATUS ASSESSMENT (1170F): Select the appropriate answer for each activity listed below

Activity	Independent	Needs Some Assistance	Dependent on Others
Bathing	☐ Patient can bathe themselves regularly	☐ Patient needs hand rails in the shower or bathtub	☐ Patient needs another person to help them bathe/shower
Dressing	☐ Patient can dress themselves	☐ Patient struggles a bit when	☐ Patient needs someone else to
Eating	☐ Patient can eat and prepare food by themselves	☐ Patient needs some assistance in preparing or eating food	☐ Patient is dependent on others for preparing food and feeding them
Transferring	☐ Patient can get in and out of bed without a problem	☐ Patient needs the assistance of guard rails to get out of bed	☐ Patient needs another person's assistance to get in and out of bed
Walking	☐ Patient can walk without the use of mobility aids	☐ Patient needs mobility aids to walk	☐ Patient is wheelchair-bound
Toilet	☐ Patient can go to the toilet by themselves	☐ Patient needs guard rails or grab bars when going to the toilet	☐ Patient is dependent on others when going to the toilet

SIX-ITEM COGNITIVE IMPAIRMENT TEST (6CIT)[1]

Questions	Scoring System		
1. What year is it?	☐ Correct (0 pts)	☐ Incorrect (4 pts)	
2. What month is it?	☐ Correct (0 pts)	☐ Incorrect (3 pts)	
3. Give the patient an address phrase to remember with 5 components *(Example: John, Doe, 24, Sunset Blvd, Los Angeles)*			
4. About what time is it (within one hour)?	☐ Correct (0 pts)	☐ Incorrect (3 pts)	
5. Count backwards from 20-1	☐ Correct (0 pts)	☐ 1 error (2 pts)	☐ More than one error (4 pts)
6. Say the months of the year in reverse	☐ Correct (0 pts)	☐ 1 error (2 pts)	☐ More than one error (4 pts)
7. Repeat address phrase (Item no. 3)	☐ Correct (0 pts) ☐ 1 error (2 pts)	☐ 2 errors (4 pts) ☐ 3 errors (6 pts)	☐ 4 errors (8 pts) ☐ All wrong (10 pts)
TOTAL SCORE			
SCORING: **0-7 Normal** **8-9 Probably significant cognitive impairment (consider referral)** **10-20 Significant cognitive impairment (refer)**			

[1]6-item Cognitive Impairment Test (6CIT) Kingshill Version 2000®

OTHER ASSESSMENTS: Complete the following assessments

Physical activity assessment (1103F)	☐ Start exercising ☐ Increase exercise	☐ Maintain current level of physical activity
Fall risk assessment	☐ Patient did not have any falls or only had 1 fall in the past year (1101F)	☐ Patient had 2 or more falls in the past year (1100F)
Urinary Incontinence Assessment (1090F)	☐ Patient is NOT incontinent	☐ Patient is incontinent and treatment plan has been discussed

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Preventive Screenings and Counseling		Date Completed	Notes and Results
Influenza vaccination	☐ Vaccine administered during today's visit (G0008) ☐ Vaccine administered previously (4037F)		
Pneumococcal vaccination	☐ Vaccine administered during today's visit (G0009) ☐ Vaccine administered previously (4040F)		
Colorectal Cancer Screening	**Patients aged 50-75 years** must complete any one of the following screenings for colorectal cancer: ☐ Colonoscopy (every 10 years) ☐ Flexible sigmoidoscopy (every 5 years) ☐ CT Colonography (every 5 years) ☐ FIT-DNA (every 3 years) ☐ Fecal Occult Blood Test (every year)		
Breast Cancer Screening	**Women aged 50-74 years** must complete a mammogram every two years.		
Cervical Cancer Screening	☐ **Women aged 24-64 years** must complete a cervical cytology every 3 years. ☐ **Women aged 30-64 years** must complete a cervical high-risk HPV testing every 5 years.		
Osteoporosis Screening	**Women aged 67-85 years who had a fracture** must complete a bone mineral density test or be dispensed osteoporosis medication within six months of the fracture date.		
Abdominal Aortic Aneurysm	**Men aged 65-75 who have smoked tobacco** are recommended to complete 1-time screening for abdominal aortic aneurysm with ultrasonography.		
Statin Therapy for Cardiovascular Disease	**Patients aged 40-75 years** who are diagnosed with CVD must be prescribed with moderate to high-intensity statin medication.		
Statin Therapy for Diabetes	**Patients aged 40-75 years** who are diagnosed with Diabetes must be prescribed with statin medication.		
Diabetes Screenings	**Diabetic patients aged 18-75 years** must complete the following screenings: ☐ Hemoglobin A1C screening at least once a year.		HbA1C Result: _____ ☐ A1C <7% (3044F) ☐ A1C ≥7% and <8 (3051F) ☐ A1C ≥8% and ≤9% (3052F)
	☐ Dilated or retinal eye exam every year. If patient had a negative result in the year prior, patient may complete eye exam every two years.		
	☐ MicroAlbumin screening every year.		
	☐ Foot exam completed by a podiatrist, as needed.		
	☐ uACR and eGFR screening every year.		

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Diagnosis/Description	Status	Plan
Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**
Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**
Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**
Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**
Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**
Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**
Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**
Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**
Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**
Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**

Provider Name: ______________________________ ☐ MD ☐ DO ☐ NP ☐ PA-C

Provider Signature: ______________________________ Date: ____________________

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Patient Name ______________________ **Date of Service** ____/____/____

Date of Birth ____/____/____ **Patient ID** ______________________

Diagnosis/Description	Status	Plan
Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**
Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**
Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**
Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**
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Diagnosis:	☐ Improving ☐ Asymptomatic ☐ Stable ☐ Declining ☐ Symptomatic ☐ End Stage	**Plan:** **Rx:**

Provider Name: ______________________ ☐ MD ☐ DO ☐ NP ☐ PA-C

Provider Signature: ______________________ Date: ______________

Submit completed form to Clever Care	Secure e-mail: AWV@ccmapd.com	eFax: (657) 276-4759