Profile: Health Conditions

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

or affix label here

Overall Health

In general, how would you say your health is?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

consider activities of daily living

How much bodily pain have you had during the past 4 weeks?

- ☐ None
- ☐ Very mild
- ☐ Moderate
- ☐ Severe
- ☐ Very severe

consider activities of daily living

How much did your health interfere with your normal activities (outside and/or inside the home) during the past 4 weeks?

- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a bit

consider activities of daily living

Vision

How is your eyesight for reading (with your glasses)?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

How is your long distance eyesight (with your glasses)?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Hearing

How is your hearing (with your hearing aid)?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Falls

Have you had a fall inside/outside the home in the past 6 months? ☐ Yes ☐ No

If yes, record number of falls

Consider both activities of daily living and need for referral if the consumer has any problems with vision, hearing or falls.

Health Conditions *(include all issues eg, allergies, acute medical conditions, disabilities, continence, dental, developmental problems)*

1.
2.
3.
4.
5.

Current Medications *(include prescriptions, over-the-counter and alternate products)*

1.
2.
3.
4.
5.
6.
7.
8.

Note: Polypharmacy may suggest a medication review is desirable

Comments

Department of Human Services

1620402D

Office Use Only: Summarise issues and arising action using the Summary and Referral Information form

Name: Designation/Agency:

Sign: Date: Contact number:

If information becomes superseded, indicate below and record updated information on a new form

The information on this form has been superseded

Date: Name: Sign: