

# The Irving Sherwood Wright Center on Aging Psychosocial Screening Form

This form is to be completed only by the patient.

Dear Patient: All kinds of life circumstances can influence a person's health and well-being. The information you provide here will better help your doctor respond to your needs. Please answer all questions and mark each box clearly. This information is private and will not be shared with anyone other than your physician. If you have questions, please ask your physician. Thank you.

**Patient's Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Q1** Is there anything we need to know about your health beliefs to help us care for you?

- No*  
 *Yes*

**Q5** Do you feel comfortable speaking in English?

- No*  
 *Yes*

**Q2** Do you ever drink alcohol? (beer, wine, or liquor, etc.)

- Never*  
 *Several times a year*  
 *Several times a week*  
 *Daily*

**Q6** Do you feel comfortable reading in English?

- No*  
 *Yes*

**Q3** Do you ever use recreational drugs? (For example: other people's prescriptions, marijuana, inhalants, cocaine, etc.)

- Never*  
 *Several times a year*  
 *Several times a week*  
 *Daily*

**Q7** What is the **highest grade** level you completed? (Check one)

- Less than 6th grade*  
 *Less than high school graduate or GED*  
 *High school graduate or GED*  
 *Some College*  
 *College Graduate*  
 *More than College Graduate*

**Q4** Do you ever deliberately misuse prescription or over-the-counter drugs?

- Never*  
 *Several times a year*  
 *Several times a week*  
 *Daily*

**Q8** With whom do you live? (Check all that apply)

*Live alone*

*With child(ren)*

*With a spouse or partner*

*Other family, \_\_\_\_\_*

*Non-Family, \_\_\_\_\_*

**Q9** Are you currently (check one)

*Married*

*Divorced*

*Living with a Partner*

*Separated*

*Single/Never Married*

*Widowed*

**Q10a** Does anyone help you meet your basic daily needs in any way?

**No** >> *Go to questions 10b AND 10c*

**Q10b** Do you think you need help in taking care of your basic needs?

*No*

*Yes*

**Q10c** Do family or friends think you need help in taking care of your basic needs?

*No*

*Yes*

**Yes** >> *Go to questions 10d AND 10e*

**Q10d** Check all the people from whom you **receive** help in caring for yourself or doing chores:

*Spouse/Partner*

*Paid Person (e.g., home aide, housekeeper, nurse)*

*Adult Child(ren)*

*Neighbor(s)*

*Child(ren) under age 18, including grandchildren*

*Friend(s)*

*Sibling(s)*

*Other, \_\_\_\_\_*

**Q10e** Do you have all the help you need?

*No*

*Yes*

**Q11** Do you have a social worker or care manager you rely on for any reason?

*No*

*Yes, please provide the social worker/case manager's name and telephone number: \_\_\_\_\_*

**Q12a** Are you **providing care** for someone other than yourself?

No

Yes >> **Q12b** Please check all of the people you are **providing care** for:

Spouse/Partner

Sibling(s)

Adult Child(ren)

Neighbor(s)

Child(ren) Under age 18,  
including grandchildren

Friend(s)

Other, \_\_\_\_\_

**Q13** How often do you feel stressed by your caregiving responsibilities?

Never

Frequently

Rarely

Nearly Always

Sometimes

**Q14** Please place an X in the boxes to show you answer to each question:

	None	1	2	3-4	5-8	9 or more
Q14a How many <b>relatives</b> do you feel close to that you can call on them for help?	<input type="checkbox"/>					
Q14b How many <b>relatives</b> do you feel at ease with that you can talk about private matters?	<input type="checkbox"/>					
Q14c How many <b>relatives</b> do you see or hear from at least once a month?	<input type="checkbox"/>					
Q14d How many <b>friends/neighbors</b> do you feel close to that you can call on them for help?	<input type="checkbox"/>					
Q14e How many <b>friends/neighbors</b> do you feel at ease with that you can talk about private matters?	<input type="checkbox"/>					
Q14f How many <b>friends/neighbors</b> do you see or hear from at least once a month?	<input type="checkbox"/>					

**Q15** Does anyone do anything to you at home that makes home a difficult place to be?

No

Yes

**Q16** During the past 4 weeks, how often have problems in your household led to insulting, swearing, threatening, yelling, hitting, or pushing?

*None of the time*

*Infrequently*

*Some of the time*

*Most of the time*

**Q17a** Do you have serious problems with any family or friends?

*No*

**Yes >> Q17b** Does this person live with you?

*No*

*Yes*

**Q18a** Have you had a change in living situation (moved to a new home)?

*No >> Skip to Question 19*

**Yes >> Go to Question 18b and 18c**

**Q18b** When did this happen?

*During the last month*

*During the last 6 months*

*During the last year*

*Longer than one year ago*

**Q18c** Does this significantly affect you now?

*No*

**Yes >> Q18d** How would you describe the impact on you now?

*Very Bad*

*Bad*

*Not much either way*

*Good*

*Very Good*

**Q19a** Has anyone close to you died?

No >> **Skip to Question 20**

Yes >> **Go to Question 19b and 19c**

**Q19b** When did this happen?

*During the last month*

*During the last 6 months*

*During the last year*

*Longer than one year ago*

**Q19c** Does this significantly affect you now?

No

Yes >> **Q19d** How would you describe the impact on you now?

*Very Bad*

*Bad*

*Not much either way*

*Good*

*Very Good*

**Q20a** Has one of your close friends or relatives had a serious health or life problem?

No >> **Skip to Question 21**

Yes >> **Go to Question 20b and 20c**

**Q20b** When did this happen?

*During the last month*

*During the last 6 months*

*During the last year*

*Longer than one year ago*

**Q20c** Does this significantly affect you now?

No

Yes >> **Q20d** How would you describe the impact on you now?

*Very Bad*

*Bad*

*Not much either way*

*Good*

*Very Good*

**Q21a** Have you been a victim of a crime?

No >> **Skip to Question 22**

Yes >> **Go to Question 21b and 21c**

**Q21b** When did this happen?

*During the last month*

*During the last 6 months*

*During the last year*

*Longer than one year ago*

**Q21c** Does this significantly affect you now?

No

Yes >> **Q21d** How would you describe the impact on you now?

*Very Bad*

*Bad*

*Not much either way*

*Good*

*Very Good*

**Q22a** Has any other major event occurred causing you stress?

No >> **Skip to Question 23**

Yes, please describe briefly: \_\_\_\_\_

*If yes >> Go to Question 22b and 22c*

**Q22b** When did this happen?

*During the last month*

*During the last 6 months*

*During the last year*

*Longer than one year ago*

**Q22c** Does this significantly affect you now?

No

Yes >> **Q22d** How would you describe the impact on you now?

*Very Bad*

*Bad*

*Not much either way*

*Good*

*Very Good*

**Q23** Do you have trouble making ends meet financially?

- No
- Yes

**Q24a** In the past month, have you been feeling depressed or down?

- No
- Yes >> **Q24b** Have you been feeling that way most of the time for at least 2 weeks?
  - No
  - Yes

**Q24c** In the past month, have you found yourself losing interest or pleasure in things you usually enjoyed?

- No
- Yes >> **Q24d** Have you been feeling that way most of the time for at least 2 weeks?
  - No
  - Yes

**Q25a** In the past month, have you had a difficult time coping with anxiety or worries?

- No
- Yes

**Q25b** Do you experience any of the following:

	No	Yes
<b>Q25bi</b> Intense fear	<input type="checkbox"/>	<input type="checkbox"/>
<b>Q25bii</b> Racing heart beat	<input type="checkbox"/>	<input type="checkbox"/>
<b>Q25biii</b> Restlessness	<input type="checkbox"/>	<input type="checkbox"/>

**Q26** Sometimes, when people feel down, they think about ending their own life. During the past 6 months, have you ever thought about ending your life?

- No
- Yes

**Q27** Are there other non-medical concerns you have or is there anything else you would like your physician to know about you?

- No
- Yes, please briefly explain your concerns: