HelicalHealth

Annual Wellness Visit

Annual Wellness visits are typically covered once every 12 months.

An annual exam is a yearly preventive visit with your doctor to check your physical and mental health. This visit helps you and your doctor plan and set health goals as well as keep track of your progress. A preventive visit or service helps prevent or find problems before you feel sick. Insurance typically covers this once every 12 months. An office visit or service most often treats new symptoms or existing health problems and is not a part of the preventive visit (thereby incurring the cost of a typical office visit).

Wellness visits do not include any clinical laboratory tests; however, the provider may separately order such tests during one of these visits. All laboratory tests are subject to applicable coverage guidelines and frequency limits. Deductible and coinsurance may be applied.

Wellness visits do not include other routine preventive services that insurance covers (i.e., Pelvic/Breast exam, Pap smear, Influenza and pneumonia vaccines, smoking cessation counseling, etc.). These services can be provided alongside a wellness visit and billed separately to your insurance. These services are subject to their own coverage guidelines and frequency limits. Deductible and coinsurance may be applied.

An additional office visit (evaluation and management) service will be provided alongside a wellness visit and billed separately if it is significant, separate, and medically necessary to treat a new or established health problem. This service is subject to its own insurance coverage guidelines and limitation. Deductible and coinsurance will be applied.

Last name: _____

Date of birth: _____

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Wellness: Health Risk Assessment

Patient Name: _____ Date of Birth: _____ Date: _____

Occupation: _____

1. In general, would you say your health is: _____Excellent _____Very Good _____Good _____Fair _____Poor

2. How have things been going for you during the past 4 weeks?
____Very well; could hardly be better
____Pretty well
____Good and bad parts about equal
____Pretty bad
____Very bad; could hardly be worse

3. How confident are you that you can control and manage most of your health problems/issues?
____Very confident
____Somewhat confident
____Not very confident
____I do not have any health problems

4. How often in the last 4 weeks have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up					
Sexual problems or concerns					
Trouble eating/swallowing					
Teeth or denture problems					
Problems using the telephone					
Tiredness or fatigue					
Problems sleeping					

5. Have you fallen two or more times in the past year? _____YES _____NO

6. Are you afraid of falling? Do you feel unsteady? _____YES _____NO

7. HOME SAFETY CHECKLIST

	Yes	No
Are entrance ways well lit?		
Are sidewalks/entrance ways maintained?		
Is a carbon monoxide detector installed?		
Are smoke detectors installed?		
Are all medicines kept in original containers with original labels intact?		
Do you throw out all unidentified or out-of-date medications?		

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8. 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 directed
___Sometimes I take them as directed
___I seldom take them as directed

9. Are you having difficulties driving your car? ___Yes, often ____Sometimes ____No ____I do not use a car

10. Do you always fasten your seat belt when you are in a car?
___Yes, always/usually
___Yes, sometimes
___No

11. How often in the last four weeks have you experienced the following?

Hearing loss screening	Never	Seldom	Sometimes	Often	Always
Straining to understand conversation					
Trouble hearing in a noisy background					
Misunderstanding what others are saying					

12. During the past 4 weeks how much have you been bothered by feelings of anxiety, depression, irritability, orsadness? _____Not at all _____Quite a bit _____Slightly _____Moderately _____Extremely

13. During the past 4 weeks, has your physical or emotional health limited your social activities with family and friends? _____Not at all _____Quite a bit _____Slightly _____Moderately _____Extremely

14. During the past 4 weeks, how much bodily pains have you generally had?
_____No Pain _____Very Mild Pain _____Mild Pain _____Moderate Pain _____Severe Pain

15. Do you have someone who is available to help you if you needed or wanted help?
___Yes, as much as I want / need
___Yes, some
___No, not at all

16. Because of any health problems, do you need the help of another person with shopping, preparation of meals,or housework? _____Yes _____No

17. Because of any health problems, do you need the help of another person with your personal care needs, suchas eating, bathing, dressing, or getting around the house? _____Yes _____No

18. Can you handle your own money without help? _____Yes _____No

19. During the past 4 weeks, did you exercise for about 20 minutes, 3 or more days a week?
___Yes, most of the time
___Yes, some of the time
___No, I usually do not exercise this much
___No, I am not currently exercising

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20. When you exercise, how intensely to you typically exercise?
____Light (stretching/slow walking)
____Moderate (brisk walking)
____Heavy (jogging/swimming)
____Very Heavy (running/stair climbing)

21. Are you a smoker/tobacco user?
(Select: ___Cigarette smoking ___Pipe or cigar smoking ___Vaping ___Snuff/chewing tobacco)
__No – never
__No – former; when did you quit? _____
__Yes, and I am interested in quitting. How many packs/day on average? _____ For how many years? _____
__Yes, but I'm not ready to quit. How many packs/day on average? _____ For how many years? _____

22. Alcohol History. Did you have a drink with alcohol in the past year? _____Yes _____No

If yes, continue. If no, skip to next section
How often did you have a drink containing alcohol in the past year?
_____Monthly _____2-4x/month _____2-3x/week _____4 or more times/week

How many drinks did you have on a typical day when you were drinking in the past year?
_____1-2 drinks _____3-4 drinks _____5-6 drinks _____7-9 drinks _____10 or more drinks

How often did you have 6 more drinks on one occasion in the past year?
_____Never _____Less than monthly _____Monthly _____Weekly _____Daily or almost daily

23. Do you have any urinary accidents (or are you scared you are going to have one)? _____Yes _____No

24. Vaccination Record

	Last Infection Date	Date received Circle One	Given by
COVID-19?	____N/A	Dose 1 _____ Moderna Pfizer J&J Dose 2 _____ Moderna Pfizer J&J Dose 3 _____ Moderna Pfizer Dose 4 _____ Moderna Pfizer	_____ _____ _____ _____
Flu	____N/A		
Pneumonia	____N/A		
Tetanus	____N/A	TdaP Td	
Shingles	____N/A	1 shot shingles 2 shot Shingrix	

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25. Health Record

Test	Date of test/procedure (most recent)	Result	Treatment
Cholesterol/lipid levels			
DEXA Scan (bone density)		_____Normal _____Abnormal	
Rectal exam		_____Normal _____Abnormal	
Colonoscopy		_____Normal	
Next colonoscopy?		_____Abnormal	

26. Do you have a cardiologist? _____Yes _____No Last echo? _____

27. Are you having memory issues, foggy brain or dizziness? _____Yes _____No

28. Are you having pain, burning, numbness or tingling in your arms or legs? _____Yes _____No

29. Diabetics History. ***Skip if this does not apply***

Diagnosis date? _____Type I Type II Mixed

HbA1c last checked? _____ What was the value? _____

Last diabetic eye exam? _____Last diabetic foot exam? _____

30. Women

Are you doing monthly self-breast exams? Yes/No

Last mammogram? _____ Normal/Abnormal Next mammogram? _____

Last pap smear? _____ Normal/Abnormal Next pap smear? _____

Men

Are you doing monthly self-breast exams? Yes/No

Are you doing monthly self-testicular exams? Yes/No

Clinical Checklist:

- ☐ Height, weight, BMI
- ☐ Blood pressure
- ☐ Visual acuity screen (eye chart)
- ☐ Advanced directive and end-of-life planning
- ☐ Counseling/education aimed at preventing chronic diseases, reducing risk factors, promoting wellness, and improving self-management of health
- ☐ Screening schedule for the next 5-10 years

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Patient Health Questionnaire (PHQ –9)

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

	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 too 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 the 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 hurting yourself	0	1	2	3
Add columns		+	+	
Total				

(Healthcare professional: For interpretation of TOTAL please refer to accompanying scoring card)

10. If you checked off any problems, how difficult have these problems made it for you to do yourwork, take care of things at home, or get along with other people?
    _____ Not difficult at all
    _____ Somewhat difficult
    _____ Very Difficult
    _____ Extremely Difficult

Provider Initials _____

Last name: _____

Date of birth: _____

List of Providers & Suppliers of Healthcare

Please list all your current providers and suppliers of healthcare

Primary Care Physician/provider(s):

Clinic/Provider Name	Location

Specialist(s):

Clinic/Provider Name	Specialty	Phone number

Alternative medicine providers (i.e., chiropractors, acupuncturists, etc.):

Clinic/Provider Name	Specialty	Phone number

Preferred pharmacy(s): Name & Location

Pharmacy Name	Location	Phone

Dentist:

Clinic/Dentist Name	Location

Other:
