

# Member Wellness Comprehensive Assessment Form



Member Last Name \_\_\_\_\_ DOB (MM/DD/YYYY) \_\_\_\_\_

Member First Name \_\_\_\_\_ DOS (MM/DD/YYYY) \_\_\_\_\_

Member ID \_\_\_\_\_ Native Language \_\_\_\_\_ Gender  Male  Female  Other

Provider \_\_\_\_\_ NPI \_\_\_\_\_

Member's PCP \_\_\_\_\_

**Physical Exam: Vital Signs**

Height (in) \_\_\_\_\_ BMI \_\_\_\_\_ HR \_\_\_\_\_ SBP \_\_\_\_\_ SpO2 \_\_\_\_\_

Weight (lbs) \_\_\_\_\_ Temp (°F) \_\_\_\_\_ RR \_\_\_\_\_ DBP \_\_\_\_\_

**Allergies:**  No known drug allergies  No known food allergies

_____	_____	_____
_____	_____	_____
_____	_____	_____

**Mediations: (List all medications, including OTCs, with dosage and frequency, or attach a printed, signed, and dated list.)**

**1159F — Medication List**  No Current Medications

1.	13.
2.	14.
3.	15.
4.	16.
5.	17.
6.	18.
7.	19.
8.	20.
9.	21.
10.	22.
11.	23.
12.	24.

**1160F — Medication List Review**

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Printed Name: \_\_\_\_\_ Provider Credentials: MD, DO, PA, NP

**Surgical History**  Reviewed and No Surgeries

_____	_____	_____
_____	_____	_____

Member Name: \_\_\_\_\_

DOB: \_\_\_\_\_ DOS: \_\_\_\_\_

**Previous Procedures and Outcomes:**

(Enter the most recent DOS and results for each)

	Date	Results		Date	Results
Colorectal Cancer Screening	_____	_____	Nephropathy Screening	_____	_____
Colonoscopy	_____	_____	Microalbuminuria	_____	_____
FIT DNA/Cologuard	_____	_____	Macroalbuminuria	_____	_____
FOBT	_____	_____	HbA1C	_____	_____
Flexible Sigmoidoscopy	_____	_____	Retinal Eye Exam	_____	_____
Bone Mineral Density Test	_____	_____	Eye Care Provider Name	_____	_____
Mammogram	_____	_____	Pneumococcal Vaccine	_____	_____
Pap Smear	_____	_____	Shingles Vaccine	_____	_____
Influenza Vaccine	_____	_____			

**Family History:**  Reviewed and No Relevant History

	Father	Mother	Children	Siblings	Grandparents
HTN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Lipids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Father	Mother	Children	Siblings	Grandparents
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Review of Systems:**      **Negative**      **Positive/Findings**

General	<input type="checkbox"/>	
HEENT	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	
Digestive/GI	<input type="checkbox"/>	
GU	<input type="checkbox"/>	
Lymphatic/Hematologic	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	
Nervous	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	
Emotional/Psychiatric	<input type="checkbox"/>	
Social History	<input type="checkbox"/> No <input type="checkbox"/> Yes	

Member Name: \_\_\_\_\_

DOB: \_\_\_\_\_

DOS: \_\_\_\_\_

**1170F — Functional Assessment**

Cognitive Status:	<input type="checkbox"/> Excellent <input type="checkbox"/> Diminished <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Parkinson <input type="checkbox"/> Other:
Ambulatory Status:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Able to Climb Stairs <input type="checkbox"/> Walks With Cane <input type="checkbox"/> Uses Wheelchair/Scooter <input type="checkbox"/> Needs Assistance <input type="checkbox"/> Amputation R/L <input type="checkbox"/> Prosthetic Devices
Hearing:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Deaf <input type="checkbox"/> Hearing Aids or Devices
Vision:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Uses Glasses <input type="checkbox"/> Uses Contacts <input type="checkbox"/> Cataract(s) <input type="checkbox"/> Glaucoma R/L <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> DM Retinopathy <input type="checkbox"/> Blind
Speech:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Other Functional Independence:	(Exercise, ability to perform job, etc.):
Smell/Taste:	<input type="checkbox"/> Normal <input type="checkbox"/> Some Changes
Touch:	<input type="checkbox"/> Intact <input type="checkbox"/> Decreased sensitivity (Hot/Cold) <input type="checkbox"/> Numbness:

**Activities of Daily Living**

	I = Independent	A = Assistance Needed	D = Dependent
Grooming	I	A	D
Dressing	I	A	D
Bathing	I	A	D
Eating	I	A	D
Transferring	I	A	D
Use of Toilet	I	A	D
Walking	I	A	D

**Advance Care Planning (CPT II 1123F, 1124F, 1157F, 1158F; CPT 99497, 99498)**

Advance Care Planning discussed:  Yes  No

Copy of Advance Care in the chart:  Yes  No

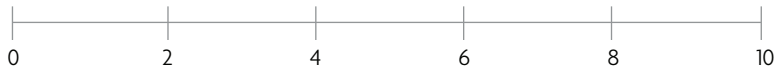
Patient has:  Advance Directive  Living Will  Actionable Medical Orders  Surrogate Decision Maker

**Pain Assessment:**

Pain:  No - 1126F  Yes - 1125F      Date of Onset: \_\_\_\_\_

Member Name: \_\_\_\_\_

DOB: \_\_\_\_\_ DOS: \_\_\_\_\_



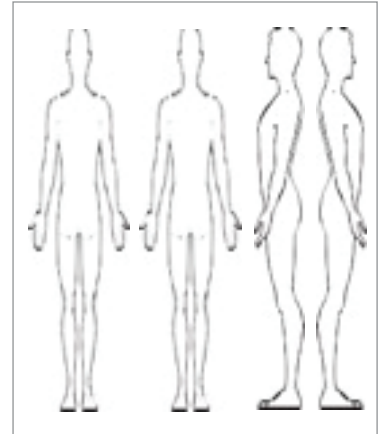
Intensity:

No Pain      Mild      Moderate      Severe      Very Severe      Worst Pain

Location: \_\_\_\_\_

Frequency:  Acute     Chronic     Intermittent     Continuous     Occasionally

Type of Pain:  Aching     Crushing     Sharp     Stabbing     Throbbing     Radiating  
 Burning     Tingling     Cramping     Other: \_\_\_\_\_



Patient/Family Education provided:  Yes  No    Psychological Support:  Yes  No    Under Pain Management:  Yes  No

If yes to Pain Management, Dr.: \_\_\_\_\_ Comments: \_\_\_\_\_

**Fall Risk Screening:** (Mark all that apply)

**Unable to perform exam b/c of:**

<input type="checkbox"/>	Diagnoses (three or more existing)	<input type="checkbox"/>	Polypharmacy (four or more medications, incl. OTC)
<input type="checkbox"/>	Prior history of falls within three months	<input type="checkbox"/>	Pain affecting level of function
<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	Cognitive Impairment
<input type="checkbox"/>	Visual Impairment	<input type="checkbox"/>	Unable to rise from seat w/o U.E.
<input type="checkbox"/>	Impaired functional mobility	<input type="checkbox"/>	Increased Fall Risk (four or more boxes marked)
<input type="checkbox"/>	Environmental Hazard		

TOTAL number of boxes marked: \_\_\_\_\_

**Depression Screening:**

<input type="checkbox"/> Unable to perform exam because the patient is unable to communicate/answer.
Have you felt depressed or down-and-out over the past two months? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a loss of interest in things that normally bring you pleasure? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you felt fatigued or had a loss of energy recently? <input type="checkbox"/> Yes <input type="checkbox"/> No
If two or more "Yes" then complete and document results from either a: <input type="checkbox"/> PHQ9 form <input type="checkbox"/> Standard Screening Tool <input type="checkbox"/> Clinical Interview
Attach Standard Screening Tool or Clinical Interview to assessment if completed.



Member Name: \_\_\_\_\_

DOB: \_\_\_\_\_ DOS: \_\_\_\_\_

**Treatment Plan:** (Document all chronic or acute conditions, and comment on current status.)

Status Key: **AE** = Acute Exacerbation    **AC** = Active Controlled    **AU** = Active Uncontrolled    **ES** = End Stage    **RS** = Resolved

No.	Diagnosis	Status	Plan
1.		AE	
2.		AE	
3.		AE	
4.		AE	
5.		AE	
6.		AE	
7.		AE	
8.		AE	
9.		AE	
10.		AE	
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Provider Signature: \_\_\_\_\_

Provider Printed Name: \_\_\_\_\_ Provider Credentials: MD, DO, PA, NP