



Patient Name:	Primary Care Physician:
DOB:	Care Manager:
Age:	Care Team:

Chronic Conditions

<input type="checkbox"/> Diabetes	Current A1c _____
<input type="checkbox"/> Hypertension	Current B/P _____
<input type="checkbox"/> BMI <19 or >30	Current BMI _____
<input type="checkbox"/> COPD/Asthma	
<input type="checkbox"/> CAD/CHF	
<input type="checkbox"/> Depression	
<input type="checkbox"/> Other: _____	
<input type="checkbox"/> _____	

Risk Stratification Score: _____

Prescription Medications – Use additional page if needed

Name	Dose	Route	When Taken	Why Taken	Additional Information

Other Concerns	Allergies	
	Item/Medication	Additional Information

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Current Self-Management

Diet:	Physical Activity:
Checking: B/P, Glucose Frequency?	What type of Device/s Used:

Health Screening and Maintenance

<input type="checkbox"/> Flu Shot	Received: _____
<input type="checkbox"/> Pneumococcal Vaccination	Received: _____
<input type="checkbox"/> Zoster Vaccination	Received: _____
<input type="checkbox"/> Stool for OB	Completed: _____
<input type="checkbox"/> Colon/signoid-oscopy	Completed: _____
<input type="checkbox"/> Dexa Scan (woman)	Completed: _____
<input type="checkbox"/> Mammogram (woman)	Completed: _____
<input type="checkbox"/> Cervical Cancer Screening	Completed: _____
<input type="checkbox"/> PSA (men)	Completed: _____
<input type="checkbox"/> Smoking Cessation Program (Note if not applicable)	Completed: _____
<input type="checkbox"/> Nutrition Evaluation (Note if not applicable)	Completed: _____
<input type="checkbox"/> Weight Management (Note if not applicable)	Completed: _____
<input type="checkbox"/> PT/OT/ST/Home Health/Hospice Referral (Note if not applicable)	Completed: _____
Completed: _____	
<input type="checkbox"/> Podiatry Exam (Note if not applicable)	Completed: _____
<input type="checkbox"/> Eye Exam	Completed: _____
<input type="checkbox"/> BMI	Completed: _____
<input type="checkbox"/> Falls/Safety Prevention	Completed: _____
<input type="checkbox"/> PHQ2	Completed: _____
<input type="checkbox"/> PHQ9	Completed: _____
<input type="checkbox"/> GAD7	Completed: _____
<input type="checkbox"/> Polst	Completed: _____
<input type="checkbox"/> Advanced Directive	Completed: _____ On File: _____

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Psychosocial needs:

Barriers to care: (transportation, finances, lack of family or social support)
Caregivers involved:
Home health:
Single level vs. Multilevel home, How many stairs if any to get in and out of your house:
ADLS: (is patient able to dress, bath, make meals, get out of bed.)
Does patient administers their own meds, fill pill boxes:
Equipment: (Use of walker, cane, Oxygen, shower chair, hospital bed.)
If applicable is pt. actively undergoing Chemo or Radiation? Intervals of treatment?

Recent Hospitalizations or ER/Urgent Care Visits
Other Providers/Chiropractors/Specialist Seen

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Other Medical Changes

Action Plan and Shared Decision Making:		
Treatment Plan	Goals	Notes

In Agreement With Action Plan and Shared Decision Making

Patient/Caregiver Date: _____

Care Manager Date: _____

PCP Date: _____