Geriatric Intake—please complete if you are over 65 years old, or if you have concerns about the the topics listed below.

Do you have medical Durable Power of Attorney for Healthcare?
[ ] No [ ] Yes (if yes, please bring a copy) Name/Relationship_______________

Do you have a living will? [ ] No [ ] Yes (If yes, please bring a copy)

We want to know **if you need help** with any of the following and **who helps you.**

Task	Don't need help	Need help	Who helps
Feeding yourself			
Getting from bed to a chair			
Getting to the toilet			
Getting dressed			
Bathing			
Using the telephone			
Taking your medicines			
Preparing your meals			
Managing money/finances/checkbook			
Doing laundry			
Doing housework			
Shopping for groceries			
Driving			
Doing handyman work			
Climbing a flight of stairs			
Getting places beyond walking distance			

Are you afraid of falling? [ ] Yes [ ] No
Have you had a fall in the past year? [ ] Yes [ ] No
If yes, please tell us about your last fall:
Date:_______
How did this fall happen:_______________
Did you need to see a doctor or other professional for treatment after this fall: [ ]Yes[] No

Do you use a walking aid such as a cane or walker (circle one) [ ] Yes [ ] No

Do you drive? [ ] Yes [ ] No