Universal Outpatient Initial Assessment Questionnaire

Our care team wants to work together with you to provide you with the best care possible. Please answer the questions below to help us understand your needs. Your provider will review your answers, and you may be asked more questions based on what you tell us. Thank you for helping us work as a team to provide you the best care.

1. **Do you have a main concern or question about your health that you would like to talk about today?**
   If yes, please explain: ____
   ____
   ____
   ____

Managing Your Pain *(Pain Management)*

2. **Do you have pain concerns related to your visit today?** ❑ Yes ❑ No
3. **Is it hard for you to control your pain?** ❑ Yes ❑ No

Activities of Daily Living *(Functional)*

4. On the scale below, check the box that best describes you:
   Most of the time, I function: ❑ Very poorly ❑ Poorly ❑ Okay ❑ Well ❑ Very well
5. **Have you fallen in the past year?** ❑ Yes ❑ No
   - If yes, why did you fall? ____
   - Are you concerned that you could fall? ____

Please check the box that best describes your abilities:	Unable to Do	With Much Difficulty	With Some Difficulty	Without Any Difficulty
6. **Can you bathe and dress yourself?**	❑	❑	❑	❑
7. **Can you keep your balance as you walk?**	❑	❑	❑	❑
8. **Can you be active, doing things such as walking, shopping, gardening?**	❑	❑	❑	❑

Eating Habits *(Nutrition)*

9. My illness or condition has made me change the kind and/or amount of food I eat. ❑ Yes ❑ No
10. **Without wanting to, I have lost or gained 10 pounds in the last 6 months.** ❑ Yes ❑ No

Sensory

11. **Sight:** ❑ No difficulty Please specify: ❑ Glasses ❑ Contacts ❑ Other__________________
12. **Hearing:** ❑ No difficulty Please specify: ❑ Hearing aid ❑ Other________________________

(Please turn page over)

PT.NO

NAME

DOB

Place EPIC Label Within Box

UW Medicine
Harborview Medical Center – UW Medical Center
Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

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Communication *(Educational and Spiritual)*

13. **Do you have any personal, religious or cultural values or beliefs we should consider when planning your care?** ❑ Yes ❑ No

    If yes, please explain:____

    ____

14. **How do you prefer to learn?** Please list preferences: ____________________

    No preferences: ❑

Your Coping Skills *(Psychosocial)*

How much of the time during the past 4 weeks:	All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
15. **Have you felt so down that it has affected your ability to do your daily activities?**	❑	❑	❑	❑	❑	❑
16. **Have you felt so down in the dumps that nothing could cheer you up?**	❑	❑	❑	❑	❑	❑

17. **Do you have:** (Check all that apply)
    - ❑ Excessive worries
    - ❑ Anxiety
    - ❑ A short temper
    - ❑ Depression
    - ❑ Agitation
    - ❑ Difficulty falling asleep
    - ❑ Difficulty staying asleep
    - ❑ Trouble thinking clearly
    - ❑ Memory problems

Your Support Community *(Discharge Planning)*

18. **Who do you live with?** (Check all that apply)
    - ❑ I live alone
    - ❑ Spouse / Partner
    - ❑ Children
    - ❑ Parents
    - ❑ Currently homeless
    - ❑ Other________________

19. **Do you have help with transportation, if needed?** ❑ No ❑ Yes If yes, check all that apply:
    - ❑ Family/Friends
    - ❑ Escort
    - ❑ Private Patient Transportation Services (cabulance)
    - ❑ Other____

Your Personal Safety

20. **Do you feel safe in your current living situation?** ❑ Yes ❑ No

Thank you for helping your UWMC care team learn about your needs. Please ask questions of your doctor or health care provider. We are all here to help you find the information you need.

Signature *(Patient or Person Authorized to Give Authorization)*

____ Date_________________

If signed by person other than patient, please define your relationship to patient:

❑ Guardian ❑ Health Care Power of Attorney ❑ Parent

❑ Spouse/Registered Domestic Partner ❑ Adult Child ❑ Other ____________________

PT.NO

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