University of Colorado Colorado Springs

HealthCircle Background Form
Aging Center – Caregiver Program

ID Number:

CONTACT INFORMATION

Legal Name: _____ (First Middle Last)

Date: ____/____/____

Preferred Name _____

Primary Language _____

Address:

Street _____

City _____

State _____

Zip _____

County _____

Phone/Email:

Check boxes if it's ok to Call (C) and/or Leave Messages (LM)

		C	LM
Home	_____	☐	☐
Cell	_____	☐	☐
Work	_____	☐	☐

OK to Send Info?

Email _____ ☐

I understand that in the event Aging Center staff are concerned about my safety because he or she was unable to get a hold of me at our scheduled appointment time, I give my permission for my therapist to contact my Emergency Contact as listed above. I understand that no information will be released other than that related to the concern about my safety, unless legal requirements relating to the reporting of threats of violence, harm or child or elder abuse or neglect apply.

Referred By: _____

How did you hear about our services? _____

Emergency Contact: _____ (First Last)

Relationship _____

Phone _____

Are you receiving other services in this building?

☐ No

☐ Yes, List Clinics _____

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DEMOGRAPHIC INFORMATION

1. Date of Birth:	____/____/____	2. Age:	_____
3. Sex:	☐ Male ☐ Female ☐ Other: _____	4. Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer
5. Education Level:	☐ Less than High School ☐ High School/GED ☐ Some College ☐ Bachelor's Degree ☐ Graduate or Professional Degree	6. Race: (check all that apply)	☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White ☐ Prefer not to answer
7. Marital and Partner Status:	☐ Never Married or Partnered ☐ Married ☐ Committed Partner ☐ Divorced ☐ Widowed	8. Sexual Orientation:	☐ Heterosexual ☐ Homosexual/Lesbian/Gay ☐ Bisexual ☐ Other: _____ ☐ Prefer not to answer
9. Employment Status:	☐ Full-Time ☐ Part-time ☐ Retired ☐ Volunteering ☐ Seeking Employment ☐ Not Employed	10. Annual Household Income: 10b. # of people supported:	☐ $0-15,000 ☐ $15,001-45,000 ☐ $45,001-75,000 ☐ $75,001+ _____
11. Type of work	☐ Desk job/sedentary ☐ Physical labor ☐ Standing or light walking ☐ Not currently working ☐ Other: _____	12. Disability Income:	☐ No ☐ Yes, List disability: _____ _____ _____
13. Military:	☐ No Military Background ☐ Active Duty Service Member ☐ Retired Service Member ☐ Active Duty Family Member ☐ Retired Family Member ☐ Reserves ☐ Former Military ☐ Former Military Family Member	14. Family changes in last 12 months? (check all that apply) 15. Are you a grandparent raising grandchildren?	☐ Marriage ☐ Divorce ☐ Births ☐ Deaths ☐ Other, List: ☐ No ☐ Yes

16. Children (including step-children) and Others living in your home:

First Name & Relationship	Age	Live with you?	First Name & Relationship	Age	Live with you?
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No
		☐ Yes ☐ No			☐ Yes ☐ No

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CARE RECIPIENT INFORMATION

1. Name of Care Recipient:	First Last	2. Social Security # (last 4 digits only)	
3. Address: Street City State Zip County		4. Phone/Email: Home Cell Work Email	Check boxes if it's ok to Call (C) and/or Leave Messages (LM) C LM OK to Send Info?
5. Date of Birth:	/ /	6. Age:	
7. Sex:	☐ Male ☐ Female ☐ Other:	8. Ethnicity:	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer
		9. Race: (check all that apply)	☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black/African American ☐ White ☐ Prefer not to answer

ABOUT YOUR CAREGIVING EXPERIENCE

1. What are your main concerns about the Care Recipient?

2. Please describe your experience on an average day with the Care Recipient:

3. Are you receiving help from anyone with your caregiving duties?

☐ No ☐ Yes, describe:

4. What are the main caregiving issues you struggle with and what you need help with in your caregiving tasks?

☐ Counseling
☐ Day Care
☐ Education/Training
☐ Information About Services
☐ Support Groups
☐ Supplemental Services
☐ In-home Sitter
☐ Overnight Respite
☐ Personal Care
☐ Other, describe:

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YOUR HEALTH

Check the health providers who have been involved in your health in the ***past year***:

Provider Type	Name	Prescribes?	Provider Type	Name	Prescribes?
☐ Primary Care or Family Medicine Provider		☐	☐ Personal Trainer		☐
			☐ Health Coach		☐
☐ Mental or Behavioral Health Clinician (counselor, psychotherapist, psychiatrist)		☐	☐ Dietitian		☐
			☐ Acupuncturist		☐
☐ Neurologist		☐	☐ Chiropractor		☐
☐ Ophthalmologist/Optometrist		☐	☐ Naturopath		☐
☐ Audiologist		☐	☐ Home Health		☐
☐ Gastroenterologist		☐	☐ Other: _____		☐
☐ Physical Therapist		☐	☐ Other: _____		☐
☐ Massage Therapist		☐	☐ Other: _____		☐

Allergies

1. Do you have any medical allergies? ☐ No ☐ Yes If yes, List: _____

SYMPTOM/PROBLEM

2. Do you currently have symptoms or problems that led you to come in today? ☐ No ☐ Yes

3. If yes, Please list any symptoms or problems you have and rate the frequency and intensity for each.

3.a.	Frequency	Rare					Almost constant
		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
	Intensity	Barely noticeable					Very intense
		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
3.b.	Frequency	Rare					Almost constant
		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
	Intensity	Barely noticeable					Very intense
		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
3.c.	Frequency	Rare					Almost constant
		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
	Intensity	Barely noticeable					Very intense
		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
3.d.	Frequency	Rare					Almost constant
		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7
	Intensity	Barely noticeable					Very intense
		☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7

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ALCOHOL AND DRUG USE

1 drink of alcohol is defined as any one of the following:
- 12 fl oz of beer
- 5 fl oz of table wine
- 1 shot of liquor

1. Alcohol (drinks per week): _____
2. Have you used alcohol excessively ***in the past year***? ☐ No ☐ Yes
3. Have you ***ever*** used alcohol excessively? ☐ No ☐ Yes
4. Has anyone in your family ***ever*** used alcohol excessively? ☐ No ☐ Yes
5. Caffeine (cups or cans per day) _____ Caffeine is contained in: Coffee, Tea, Soda and Energy Drinks
6. Tobacco (amount per day): _____
7. Has anyone in your family ***ever*** used tobacco? ☐ No ☐ Yes
8. E-cigarette or Vaporizer (amount per day): _____
9. Do you use marijuana? ☐ No ☐ Yes Frequency: _____ Purpose: _____
10. Have you used recreational drugs (drugs not prescribed to you) ***in the past year***? ☐ No ☐ Yes List: _____
11. Have you ***ever*** used recreational drugs? ☐ No ☐ Yes List: _____
12. Has anyone in your family ***ever*** used recreational drugs? ☐ No ☐ Yes List:

PRESCRIBED MEDICATIONS (include those prescribed by a health provider)

PRESCRIPTION MEDICATIONS			OVER-THE-COUNTER MEDICATIONS OR NATURAL SUPPLEMENTS		
Name of Medication	Dose	Frequency	Name of Medication	Dose	Frequency

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PROMIS – Global Health

Please respond to each item by marking one box per row.

	Excellent	Very good	Good	Fair	Poor
1. In general, would you say your health is:	5	4	3	2	1
2. In general, would you say your quality of life is:	5	4	3	2	1
3. In general, how would you rate your physical health?	5	4	3	2	1
4. In general, how would you rate your mental health, including your mood and your ability to think?	5	4	3	2	1
5. In general, how would you rate your satisfaction with your social activities and relationships?	5	4	3	2	1
6. In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	5	4	3	2	1
7. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	Completely 5	Mostly 4	Moderately 3	A little 2	Not at all 1
8. In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	Never 5	Rarely 4	Sometimes 3	Often 2	Always 1
9. In the past 7 days, my sleep quality was	Very poor 1	Poor 2	Fair 3	Good 4	Very good 5
10. In the past 7 days, how would you rate your fatigue on average?	None 5	Mild 4	Moderate 3	Severe 2	Very Severe 1
11. In the past 7 days, how would you rate your pain on average?	No Pain 0	1	2	3	4	5	6	7	8	9	Worst imaginable Pain 10
12. Location of Pain:					

DSM-5 Level 1

Instructions: The questions below ask about things that might have bothered you.

During the past ***TWO (2) WEEKS***, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
1. Little interest or pleasure in doing things?	0	1	2	3	4
2. Feeling down, depressed, or hopeless?	0	1	2	3	4
3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4
5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4

During the past ***TWO (2) WEEKS***, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	
6. Feeling nervous, anxious, frightened, worried, or on edge?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
7. Feeling panic or being frightened?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
8. Avoiding situations that make you anxious?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
10. Feeling that your illnesses are not being taken seriously enough?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
11. Thoughts of actually hurting yourself?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
12. Hearing things other people couldn't hear, such as voices even when no one was around?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
14. Problems with sleep that affected your sleep quality over all?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
17. Feeling driven to perform certain behaviors or mental acts over and over again?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
19. Not knowing who you really are or what you want out of life?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
20. Not feeling close to other people or enjoying your relationships with them?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
21. Drinking at least 4 drinks of any kind of alcohol in a single day?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	
23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	

PC-PTSD

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you . . .

1. Have had nightmares about it or thought about it when you did not want to?	☐ 1 Yes	☐ 0 No
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	☐ 1 Yes	☐ 0 No
3. Were constantly on guard, watchful, or easily startled?	☐ 1 Yes	☐ 0 No
4. Felt numb or detached from others, activities, or your surroundings?	☐ 1 Yes	☐ 0 No

SCREEN IIAB

For each question, check **only one** box that describes you **best.** Your response should reflect your **typical eating habits.** Feel free to write **comments** beside any question.

1. Has your weight changed in the past 6 months?

No/Unsure	Yes, I **gained** . . .	Yes, I **lost** . . .
☐ 8 No, my weight stayed within a few pounds.	☐ 0 More than 10 pounds	☐ 0 More than 10 pounds
☐ 0 I don't know how much I weigh or if my weight has changed.	☐ 2 6 to 10 pounds	☐ 2 6 to 10 pounds
	☐ 4 About 5 pounds	☐ 4 About 5 pounds

2. Do you skip meals?	Never or rarely ☐ 8	Sometimes ☐ 4	Often ☐ 2	Almost every day ☐ 0
3. How would you describe your appetite?	Very good ☐ 8	Good ☐ 4	Fair ☐ 2	Poor ☐ 0
4. Do you cough, choke or have pain when swallowing food OR fluids?	Never ☐ 8	Rarely ☐ 4	Sometimes ☐ 2	Often or always ☐ 0
5. How many pieces or servings of fruit and vegetables do you eat in a day? *Fruit and vegetables can be canned, fresh, frozen, or juice.*	Five or more ☐ 4	Four ☐ 3	Three ☐ 2	Two ☐ 1	Less than two ☐ 0
6. How much fluid do you drink in a day? *Examples are water, tea, coffee, herbal drinks, juice, and soft drinks, but not alcohol.*	Eight or more cups ☐ 4	Five to seven cups ☐ 3	Three to four cups ☐ 2	About two cups ☐ 1	Less than two cups ☐ 0
7. Do you eat one or more meals a day with someone?	Never or rarely ☐ 8	Sometimes ☐ 4	Often ☐ 2	Almost always ☐ 0

8. Which statement best describes meal preparation for you?

- ☐ 4 I enjoy cooking most of my meals.
- ☐ 2 I *sometimes* find cooking a chore.
- ☐ 0 I *usually* find cooking a chore.
- ☐ 4 I'm *satisfied* with the quality of food prepared by others.
- ☐ 0 I'm *not satisfied* with the quality of food prepared by others.

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PHYSICAL ACTIVITY

1a. Are you regularly physically active for approximately 150 mins/week or 30 mins/day on most days?

- ☐ Yes: I have been physically active for more than 6 months
- ☐ Yes: I have become physically active within past 6 months
- ☐ Yes: I am physically active once in a while, not consistently
- ☐ No: I have been thinking about becoming physically active, not yet
- ☐ No: I am not physically active, nor planning to become physically active

1b. If no, how long has it been since you have been physically active?

_____ (months)

2. When are you physically active?

- ☐ At work
- ☐ At home
- ☐ Transportation
- ☐ Leisure time
- ☐ Other, describe:

3. What type of physical activities are you currently performing? *(Check all that apply)*

☐ Not physically active	☐ Pilates	☐ Tennis
☐ Walking	☐ Group fitness class	☐ Pickleball
☐ Hiking	☐ Yoga	☐ Tai Chi
☐ Jogging/running	☐ Golf	☐ Meditation
☐ Stretching	☐ Strength training	☐ Other, Describe:
☐ Team sports	☐ Cycling	

4. In the past 7 days, how often did you do the following types of activities . . .	Number of days you did this activity	Average number of minutes/day?
4a. Vigorous physical activity		
4b. Walking		
4c. Sitting		

5. What time of day are you typically physically active?

- ☐ Not physically active
- ☐ Morning
- ☐ Afternoon
- ☐ Evening

6. Which social context do you prefer for workouts?

☐ Not currently active	☐ Family member
☐ Myself/alone	☐ With a small group/team
☐ Trainer/coach	☐ With a large group/team
☐ Friend	

7. Has a healthcare professional suggested physical activity for any of the following symptoms: *(Check all that apply)*

☐ Arthritis	☐ Weight gain
☐ Anxiety	☐ Pain
☐ Fatigue	☐ Poor sleep
☐ Depression	☐ Other, Describe: _____
☐ Stress	

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HEALTH HISTORY

For each item listed indicate your lifetime, past year and family history by placing a check in the column.
Self: Lifetime - Applies to you at ***ANY*** time in your life.
Self: Past Year - YOU have had in the ***past 12 months***.
Family – (Left side only) Any of the following that *your mother, father, or siblings* have ever had.

Self		Family		Self		
Life-time	Past Year			Life-time	Past Year	
			Abnormal heart rhythm			Immunizations up to date
			Alzheimer's/Dementia			Use birth control
			Arthritis			Ever been pregnant
			Asthma			Sexually transmitted diseases
			Bone density problems (osteoporosis or osteopenia)			Had abortion, miscarriage or still birth
			Cancer			Wear bike helmet
			Chicken pox			Use seat belt regularly
			Depression			Exercise regularly
			Diabetes			Special diet, List:
			Eating disorder			Digestion issues:
			Gastritis/ulcer			Gas
			Heart attack			Bloat
			Heart disease			Constipation
			High blood pressure			Diarrhea
			High cholesterol			Falls: How many in past year?__
			Kidney problems			Headaches
			Liver problems			Head Injury
			Measles			Serious Injury
			Mumps			Bone fractures
			Other mental health problem			Joint replacement
			Rheumatic fever			Back pain
			Stroke			Numbness
			Thyroid problems			Tingling
			Tuberculosis			Swelling

SURGICAL HISTORY (lifetime)	
Year	Describe

		Traumatic event
		Exposure to chemicals
		Feel safe in relationships
		Physical abuse
		Sexual abuse
		Suicide attempt

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SCREENING HISTORY

1. Visual Difficulties:
   - ☐ Cataracts
   - ☐ Diabetic retinal disease
   - ☐ Macular degeneration
   - ☐ Hypertensive retinal disease
   - ☐ Glaucoma
   - ☐ Other, describe: _____

2. Hearing Difficulties:
   - ☐ Hearing aids
   - ☐ Hearing Problems without aids
   - ☐ Other, describe: _____

3. Mobility Assistive Devices:
   - ☐ Cane
   - ☐ Walker
   - ☐ Wheelchair
   - ☐ Prosthesis
   - ☐ Other, describe: _____

LAST QUESTION!

1. What does a "Healthy You" look like?