Medicare/Cigna 360 Assessment Questionnaire

Name: _____Date of Birth:_____

Preferred pharmacy? _____

1. How is your physical activity as compared to last year? Better, Worse, or Same
2. Do you have difficulty with bathing? Yes or No
3. Do you have difficulty with grooming? Yes or No
4. Do you have difficulty with eating? Yes or No
5. Do you have difficulty with dressing? Yes or No
6. Do you have difficulty with toileting? Yes or No
7. Do you require assistance with walking or transferring? Yes or No
8. Do you require assistance with managing finances? Yes or No
9. Do you require assistance with transportation? Yes or No
10. Do you require assistance with meal preparation? Yes or No
11. Do you require assistance with shopping? Yes or No
12. Do you require assistance with managing/obtaining medications? Yes or No
13. Do you have difficulty with using the telephone? Yes or No
14. During the last 3 months have you leaked urine? Yes or No
15. What is your overall pain presence in your day to day life? 0 (none)- 10(worst) _____
16. Have you required/used more than a 15-day supply of narcotic medications over the last 12 months for non-terminal diagnosis? Yes or No

17. How is your memory as compared to last year? Better, Worse, or Same

18. Have you fallen in your home in the last 3 months? Yes or No

19. Do you require a behavioral health referral? _____

20. Do you need a referral for a case manager? _____

21. Do you see any specialists? Yes or No

    a. If yes, who and why?_____

22. Do you use any durable medical equipment (ie nebulizer, CPAP, walker, etc? Yes or No

    a. If so, which company do you use? _____

23. Do you have a living will, medical power of attorney or DNR? Yes or No Please provide paperwork