DIET & NUTRITION

Self Assessment

These questions are designed for you to reflect and identify possible concerns related to nutrition. Answering these questions can help prompt conversations with your primary care provider or other health services about problems that may be concerning you. You can take this checklist with you to your next appointment as a reminder of what you would like to discuss.

Tick all that apply:

- ☐ I have lost weight over the last 6 months
- ☐ My appetite or taste has changed
- ☐ I find it difficult to prepare food for myself
- ☐ I have problems with chewing or swallowing
- ☐ I often miss or skip meals
- ☐ I would like to improve my diet

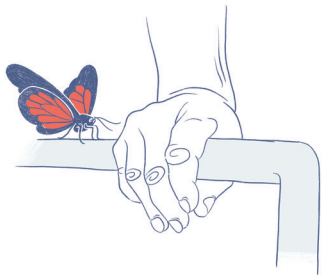
FRAILTY

Self Assessment

These questions are designed for you to reflect and identify possible indicators of prefrailty/frailty. Answering these questions can help prompt conversations with your primary care provider or other health services about problems that may be concerning you. You can take this checklist with you to your next appointment as a reminder of what you would like to discuss.

Tick all that apply:

- ☐ I am regularly very tired
- ☐ I cannot walk up one flight of stairs
- ☐ I cannot walk short distances (200 metres)
- ☐ I have more than 3 illnesses/diagnoses
- ☐ I have noticed weight loss in the last 6 months
- ☐ I have concerns or problems with my mouth/teeth
- ☐ I need support to understand my health conditions and/or medications
- ☐ I have had a fall in the last 6 months
- ☐ I feel I need more support at home (e.g. cooking, showering, cleaning)
- ☐ I feel lonely or isolated
- ☐ I have concerns about my memory
- ☐ I often feel low in mood
- ☐ I have concerns about toileting/incontinence



HEARING & VISION

Self Assessment

These questions are designed for you to reflect and identify possible concerns related to hearing/vision. Answering these questions can help prompt conversations with your primary care provider or other health services about problems that may be concerning you. You can take this checklist with you to your next appointment as a reminder of what you would like to discuss.

Tick all that apply:

- ☐ I have difficulty doing things I enjoy because of my vision/hearing
- ☐ I have difficulty doing tasks for daily living e.g. showering because of vision/hearing
- ☐ I struggle to communicate with other people due to my vision/hearing
- ☐ I feel my vision/hearing has changed in the last 6 months
- ☐ My family/friends have concerns about my safety due to my vision/hearing e.g. driving

MEMORY & COGNITIVE CHANGES

Self Assessment

These questions are designed for you to reflect and identify possible concerns related to memory/cognition. Answering these questions can help prompt conversations with your primary care provider or other health services about problems that may be concerning you. You can take this checklist with you to your next appointment as a reminder of what you would like to discuss.

Tick all that apply:

- ☐ I feel my memory and/or cognition is getting worse
- ☐ My memory and/or cognition impacts my ability to do activities I usually enjoy
- ☐ My memory and/or cognition impacts my ability to do everyday tasks e.g. making a meal
- ☐ My family/friends have concerns about my safety due to my memory and/or cognition

PAIN

Self Assessment

These questions are designed for you to reflect and identify possible concerns related to pain. Answering these questions can help prompt conversations with your primary care provider or other health services about problems that may be concerning you. You can take this checklist with you to your next appointment as a reminder of what you would like to discuss.

Tick all that apply:

- ☐ I experience pain on a daily basis
- ☐ I take medication to manage my pain on a daily basis
- ☐ Pain impacts my ability to participate in activities I usually enjoy
- ☐ Pain impacts my ability to perform tasks for daily living e.g. showering, cooking
- ☐ The pain I experience is negatively affecting my mood
- ☐ I would like more support from my primary care provider for managing my pain

PHYSICAL FITNESS & MOBILITY

Self Assessment

These questions are designed for you to reflect and identify possible concerns related to physical fitness. Answering these questions can help prompt conversations with your primary care provider or other health services about problems that may be concerning you. You can take this checklist with you to your next appointment as a reminder of what you would like to discuss.

Tick all that apply:

- ☐ I have difficulty getting up out of a chair
- ☐ I have difficulty walking short distances
- ☐ I worry about falling or injury
- ☐ I have had a fall in the last 6 months
- ☐ I have difficulty doing tasks of daily living (showering, cooking, cleaning) due to my physical ability
- ☐ I would struggle to get up off the floor on my own if I fell
- ☐ I would like to improve my physical ability

SLEEP

Self Assessment

These questions are designed for you to reflect and identify possible concerns related to sleep. Answering these questions can help prompt conversations with your primary care provider or other health services about problems that may be concerning you. You can take this checklist with you to your next appointment as a reminder of what you would like to discuss.

Tick all that apply:

- ☐ I have difficulty falling asleep
- ☐ I often wake up during the night and have trouble getting back to sleep.
- ☐ I often experience restless or disturbed sleep.
- ☐ I struggle to fall asleep when I get into bed
- ☐ My sleep problems have been affecting my daily life and activities
- ☐ I often fall asleep during the day
- ☐ I am regularly very tired
- ☐ I take medication to help me sleep regularly

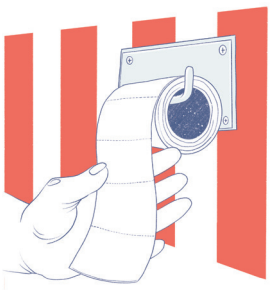
TOILETING

Self Assessment

These questions are designed for you to reflect and identify possible concerns related to toileting. Answering these questions can help prompt conversations with your primary care provider or other health services about problems that may be concerning you. You can take this checklist with you to your next appointment as a reminder of what you would like to discuss.

Tick all that apply:

- ☐ I experience incontinence of urine on a daily basis
- ☐ I experience bowel incontinence on a daily basis
- ☐ I experience pain or discomfort when passing urine or bowel motions
- ☐ I take medications (laxatives) to support bowel movements on a regular basis
- ☐ Toileting problems impact my ability to participate in activities I usually enjoy
- ☐ I would like further support to manage a toileting problem
- ☐ I have never had a bowel screening check or colonoscopy



LONELINESS & GRIEF

Self Assessment

These questions are designed for you to reflect and identify possible areas you may like to get support. Answering these questions can help prompt conversations with your primary care provider or other health services about problems that may be concerning you.

Tick all that apply:

- ☐ I would like more support with personal cares (e.g. showering, dressing, toileting)
- ☐ I would like more support with legal/financial issues (e.g. future planning)
- ☐ I would like support for transport (e.g. transport to appointments, social visits, shopping)
- ☐ I would like more support to maintain my home (e.g. cleaning, gardening, maintenance)
- ☐ I would like more support for loneliness (e.g. someone to talk to, visiting friends/family, making new connections, exploring hobbies)
- ☐ I would like more support for grief/depression (e.g. someone to talk to, professional consultation)