# Health Needs Assessment

***Please answer all the questions. Use a different form for each adult.***

First Name _____ Last Name _____

Date of Birth _____ Member ID # _____

Preferred Mailing Address _____

_____

Preferred Phone Number _____ Preferred Email _____

**Race**

☐ Asian
☐ White
☐ Unknown
☐ Decline to answer
☐ American Indian/Alaska Native
☐ Black/African American
☐ Native Hawaiian/Pacific Islander
☐ Other _____

**Ethnicity**

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown
☐ Decline to answer
☐ Other _____

**Preferred Language**

☐ English
☐ Spanish
☐ Other _____

**What is your gender identity?**

☐ Female ☐ Male ☐ Non-binary (Don't identify as either) ☐ Transgender ☐ Unknown ☐ Decline to answer

**Are you pregnant?** ☐ Yes ☐ No ☐ Decline to answer ☐ Unknown

**What is the highest level of education you have completed?**

☐ No schooling completed ☐ Grade school to 8th grade ☐ Some high school, no diploma ☐ High school graduate, diploma, or equivalent (GED, etc.) ☐ Some college credit, no degree

☐ Trade/Technical/Vocational training ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree

☐ Doctorate Degree or equivalent ☐ Decline to answer ☐ Unknown

**Do you find it hard to understand what your doctor tells you about your health?**

☐ Yes ☐ No ☐ Decline to answer

If yes, please explain: _____

Do you need help? ☐ Yes ☐ No ☐ Decline to answer

**Do you need information on a Living Will or Power of Attorney for Health Care?**

☐ Yes ☐ No ☐ Decline to answer

If yes, please explain: _____

**Do you need help completing a Living Will or Power of Attorney for Health Care?**

☐ Yes ☐ No ☐ Decline to answer

If yes, please explain: _____

## GLOBAL HEALTH AND SAFETY

**In general, how would you rate your health:**

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Unknown ☐ Decline to answer

If poor, please explain: _____

**Do you have a doctor or health care provider?**

☐ Yes What is your provider's name? _____

☐ No Would you like help finding a provider? ☐ Yes ☐ No ☐ Decline to answer

**Do you see a specialist?**

☐ Yes What is your specialist's name? _____

☐ No ☐ Unknown ☐ Decline to answer

**Do you see a mental health provider?**

☐ Yes What is your provider's name? _____

☐ No ☐ Unknown ☐ Decline to answer

**Do you use an urgent care facility or hospital for regular care?**

☐ Yes What are the facilities' names? _____

☐ No ☐ Unknown ☐ Decline to answer

**Have you been to the emergency room in the last year?**

☐ Yes ☐ No ☐ Decline to answer

If yes, how many times? ☐ One ☐ Two ☐ Three ☐ More than three

What were the reasons(s) for your emergency visit? _____

**Have you stayed overnight in the hospital in the last year?**

☐ Yes ☐ No ☐ Decline to answer

If yes, how many times? ☐ One ☐ Two ☐ Three ☐ More than three

What were the reasons(s) for your overnight hospital stay? _____

**How many medicines are you currently taking that were prescribed by your doctor or over the counter?**

☐ None ☐ 1-3 prescriptions ☐ 4-7 prescriptions ☐ 8 or more prescriptions ☐ Unknown ☐ Decline to answer

**Does anything prevent you from taking your medicines the way your doctor or health care provider wants you to?**

☐ Yes ☐ No ☐ Decline to answer

If yes, what prevents you from taking your medicine? _____

**Do you ever forget to take your medicine?** ☐ Yes ☐ No ☐ Sometimes ☐ Unknown ☐ Decline to answer

**Do you need help with your medications?**

☐ Yes ☐ No ☐ Decline to answer

If yes, please explain: _____

**When was the last time you saw a dentist?**

☐ In last 6 months ☐ In last 12 months ☐ More than 12 months ☐ Never ☐ Unknown ☐ Decline to answer

Do you need help with dental care? ☐ Yes ☐ No ☐ Decline to answer

**What is your height?** _____ feet _____ inches **What is your weight?** _____ pounds

**Do you participate in regular physical activity?**

☐ Yes ☐ No ☐ I am unable to exercise due to medical conditions ☐ Unknown ☐ Decline to answer

Do you need help with physical activity? ☐ Yes ☐ No ☐ Decline to answer

## SOCIAL CONCERNS

**Please describe your housing situation.**

☐ Own home ☐ Live with family ☐ Rent ☐ Temporary ☐ Group home ☐ Homeless/shelter

Do you need help with housing? ☐ Yes ☐ No ☐ Decline help

If yes, please explain: _____

**Do you always feel safe in your home and around all the people in your life?**

☐ Yes ☐ No ☐ Decline to answer

If no, please explain: _____

Do you need help with personal safety? ☐ Yes ☐ No ☐ Decline help

**Do you usually have enough food in your household?** ☐ Yes ☐ No ☐ Decline to answer

If no, what problems are you having related to food? _____

**Are you having any concerns with the following Social Determinants of Health?**

- Employment ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help
  ☐ No, but I'm interested in a volunteer or paid job ☐ I'm interested in a volunteer or paid job
  Are you interested in information/resources for training or preparation for entering the workforce? ☐ Yes ☐ No
- Transportation ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help
- Legal issues ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help
- Money management ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help
- Utilities ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help
- Childcare ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help
- Shopping ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help
- Overnight care ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help
- Phone ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help
- Medical care/medicine/ medical supplies ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help
- Vision ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help
- Public benefits ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help
- Debt/loan repayment ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help

If you said yes to any of the above the questions, what are your concerns?

_____

_____

_____

**Do you have any concerns with activities of daily living (ADL's)?** ☐ Yes ☐ No ☐ Decline to answer

**Do you have a primary caregiver who helps you on a regular basis**? ☐ Yes ☐ No ☐ Decline to answer

If no, do you need a caregiver? ☐ Yes ☐ No ☐ Decline help

If yes, are they adequately supporting your health care needs? ☐ Yes ☐ No ☐ Decline to answer

Who is your caregiver? ☐ Agency ☐ Family ☐ Friend ☐ Other ☐ Decline to answer

Agency caregiver's name _____ Phone number _____

Family caregiver's name _____ Phone number _____

Friend caregiver's name _____ Phone number _____

Other caregiver's name _____ Phone number _____

## PHYSICAL HEALTH

**Do you have any of the following?** ☐ Lung problems ☐ Heart disease ☐ Stroke ☐ Diabetes ☐ Cancer

☐ Back pain and musculoskeletal disorders ☐ Overweight/obesity ☐ Mental illness ☐ Substance use or abuse

**Do you have any other conditions not listed above?** _____

_____

**Have you recently or you currently experiencing any of the following?** ☐ Shortness of breath ☐ Chest pain

☐ High blood pressure ☐ Rapid weight loss or gain ☐ Fainting ☐ Thoughts of harming yourself

**If experiencing any of the above symptoms, are they new or getting worse?** ☐ Yes ☐ No ☐ Decline to answer

If yes, is your doctor/provider aware? ☐ Yes ☐ No ☐ Decline to answer

If no, do you need help contacting your doctor/provider? ☐ Yes ☐ No ☐ Decline help

## BEHAVIORAL HEALTH

**During the past month, have you often been bothered by feeling down, depressed, or hopeless?**

☐ Yes ☐ No ☐ Decline to answer ☐ Decline help

**During the past month, have you often been bothered by little interest or pleasure in doing things?**

☐ Yes ☐ No ☐ Decline to answer ☐ Decline help

**On average, how many alcoholic beverages do you drink weekly?**

☐ None ☐ 1-5 ☐ 5 or more ☐ Decline to answer

If 1 or more, any interest in reducing intake or quitting? ☐ Yes ☐ No ☐ Decline help

**Do you misuse any nonprescription drugs or substances?**

☐ Yes ☐ No ☐ Decline to answer

If yes, any interest in quitting? ☐ Yes ☐ No ☐ Decline help

**Do you smoke or use chewing tobacco?** ☐ Yes ☐ No ☐ Decline to answer

If yes, any interest in reducing or quitting? ☐ Yes ☐ No ☐ Decline help

*Please make sure you answered all the questions above. Thank you for your time.*