

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 about 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 any concerns with your overall health or wellbeing?

- Yes No Decline to answer

If yes, please explain: _____

Do you need any help with your overall health and wellbeing?

- Yes No Decline to answer

If yes, please explain: _____

What do you do to take care of yourself?

What do you see as your strengths?

Do you have any concerns with your hearing or speech?

- Yes No Decline to answer

If yes, please explain: _____

Do you need help with your hearing or speech? Yes No Decline help

If yes, 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

What is your current or most recent blood pressure? _____

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 (ADLs)? Yes No Decline to answer

Do you need help with independent ADLs like making meals, housework, shopping? Yes No Decline help

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 Substance use or abuse

HIV Learning Disability Sickle Cell Disease

Depression Bipolar Schizophrenia Anxiety

Do you need help with any of these conditions? Yes No Decline help

If yes, please explain: _____

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 check to make sure you answered all the questions.
We will call you after we receive your completed survey. Thank you.