Health Care Needs Questionnaire

Please answer the following questions to the best of your knowledge. It is not required that you complete this form. However, it is to your benefit to answer these questions because it will help us identify what health care package best meets your individual needs. If you are uncomfortable answering any portion of this questionnaire, then ignore the question and move to the next question. All information you provide will remain confidential.

1. **In general, compared to other people your age, how would you rate your health?** (select only one)
   a. Excellent
   b. Very good
   c. Good
   d. Fair
   e. Poor

2. **In general, compared to other people your age, how would you rate your mental health?** (select only one)
   a. Excellent
   b. Very good
   c. Good
   d. Fair
   e. Poor

3. **Are you currently receiving services on a daily basis from family, friends, or an agency/paid provider for each of the following activities?** (answer each question)

YES	NO	
		Personal hygiene/grooming--such as brushing teeth, washing face, combing hair
		Assistance walking or if you use a wheelchair, help once seated in chair
		Help transferring from one place to another--such as moving from chair to bed, chair to toilet or bed to standing position
		Help eating -- Using a feeding tube or someone needing to feed you with a fork or spoon
		Managing medications--includes help with reminders to take medicines, opening bottles, taking the correct dosage, giving injections

4. **In the last twelve months, how many times did you stay one or more nights in a hospital?** (do not count hospitalized for childbirth)
    a. Not been hospitalized in the last twelve months
    b. One time
    c. Two times
    d. Three or more times

5. **If hospitalized in the last twelve months, were any of these hospital stays related to mental health issues?**
    a. Not hospitalized in last twelve months
    b. None for mental health problem
    c. One time for mental health problem
    d. Two times for mental health problem
    e. Three or more times for mental health problem

6. **In the last twelve months, how many times have you used an emergency room?**
    a. Not used emergency room in the last twelve months
    b. One to two times
    c. Three to five times
    d. Greater than five times

7. **In the last twelve months, how many times have you been seen in an office or clinic by a medical professional for a physical health or a mental health concern?**
    Bubble: (A 'medical professional' could be a doctor, nurse practitioner, physician assistant or mental health professional.)
    a. No visits in last twelve months
    b. One to four times
    c. Five to nine times
    d. Ten or more times

8. **Has a doctor, nurse or health professional ever diagnosed or treated you for concerns of any of the following:**
    a. Alcohol
    b. Street Drugs
    c. Prescription Medication Use

9. **Are you concerned about your use of alcohol or drugs?** Y/N
    Bubble: (If you are uncomfortable answering any portion of this questionnaire, then ignore the question and move to the next question.)

10. **Is a friend, relative or anyone else concerned about your use of alcohol or drugs?** Y/N
    Bubble: (If you are uncomfortable answering any portion of this questionnaire, then ignore the question and move to the next question.)

11. **How many medications is your doctor currently directing you to take?**
    Count each bottle of medication only once, even if you take it often.
    Include inhalers and liquids. Do not count over-the-counter (non-prescription) medications?
    a. Not taking any medications at this time.
    b. Currently taking one to three medications.
    c. Currently taking four to eight medications.
    d. Currently taking more than eight medications.

12. My height is: _____ feet and ___ inches
    My weight is: _____ pounds

13. **Has a doctor, nurse, or other health professional EVER told you that you had any of the following?** For each, select "Yes," "No," or you're "Not sure."
bubble: (A 'medical professional' could be a doctor, nurse practitioner, physician assistant or mental health professional.)
bubble: (Do not be concerned if you have not heard of a condition on this list. Just check 'Don't Know/Not Sure")

YES	NO	Don't Know / Not Sure	
			Active cancer treatment
			ALS or muscular dystrophy
			Asthma
			Autism
			Bipolar disorder
			Bleeding disease (hemophilia)
			Cystic fibrosis
			Depression
			Diabetes
			Emphysema/COPD
			Heart attack
			Heart failure or Heart transplant
			HIV or AIDS or Other immune deficiency
			Intellectual disability (previously called mental retardation)
			Kidney failure or dialysis
			Leukemia
			Liver failure/cirrhosis or Liver transplant
			Lung (pulmonary) hypertension
			Lung transplant
			Multiple sclerosis
			Obsessive Compulsive Disorder
			Pancreas transplant
			Panic Disorder
			Peritonitis
			Post Traumatic Stress Disorder
			Psychotic disorder
			Quadriplegia or paraplegia
			Schizophrenia or Schizoaffective Disorder
			Severe joint or back pain
			Sickle cell disease
			Skin ulcers/wounds
			Stroke
			Substance use disorder
			Tracheostomy or ventilator
			Ulcerative colitis/Crohn's disease

14. **Please provide the name of the most recent physician office/clinic that you have visited, along with the city or county location:**
Physician or Clinic Name: _____
City or County: _____