# Health Survey

Participant Name or Identifier: _____ Survey Date: _____

For office use: LACE: _____ TOC: _____

| 1. How comfortable are you with **filling out forms** and **applications** by yourself? (circle one) | | | | |
|---|---|---|---|---|
| Extremely | Quite a bit | Somewhat | A little bit | Not at all |

| 2. In general, how do you feel about the **quality of your health**? (circle one) | | | | |
|---|---|---|---|---|
| Excellent | Very Good | Good | Fair | Poor |

| 3. How would you rate the **quality of your life** in the past week? (circle one) | | | | |
|---|---|---|---|---|
| Excellent | Very Good | Good | Fair | Poor |

| During the past week, how much has your health interfered with your: (circle one) | Not at all | Very Little | Moderately | Quite a bit | Totally |
|---|---|---|---|---|---|
| 4**. Normal activities** with family, friends, neighbors, or groups? | 0 | 1 | 2 | 3 | 4 |
| 5. H**obbies** or **recreational activities** ? | 0 | 1 | 2 | 3 | 4 |
| 6. **Household chores** ? | 0 | 1 | 2 | 3 | 4 |
| 7. E**rrands** and **shopping** ? | 0 | 1 | 2 | 3 | 4 |

| 8. Please circle the number below that describes your **stress** in the past week: | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |
| No stress | | | | Severe stress |

| 9. Please circle the number below that describes your **pain** in the past week: | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |
| No pain | | | | Severe pain |

| 10. Please circle the number below that describes your **sleep** in the past week: | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |
| Good Sleep | | | | No Sleep |

| 11. Please circle the number below that describes how **overwhelmed** you have felt in the past week: | | | | |
|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 |
| Not overwhelmed | | | | Overwhelmed |

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| How much **time** during the past week were you bothered by: (circle a number for each question) | | | | | |
|---|---|---|---|---|---|
| | Not at all | Some of the time | More than half of the time | Nearly every day | Every day |
| 12. **Little interest** or **pleasure** in doing things? | 0 | 1 | 2 | 3 | 4 |
| 13. **Feeling down, depressed** or **hopeless**? | 0 | 1 | 2 | 3 | 4 |

| | | |
|---|---|---|
| 14. Do you **forget** or **choose not** to take your medication? | Yes | No |
| 15. Do you know the **name** of each of the **medications you are taking** and what you are **taking each one** for? | Yes | No |
| 16. Do you **forget to refill** your prescriptions **on time**? | Yes | No |
| 17. Do you have **barriers** that prevent you from **filling your prescriptions**? | Yes | No |
| 18. Do you have a way of **managing** your **medications** to avoid errors? | Yes | No |

| 19. Do you know how to **access** your hospital **patient portal**? | |
|---|---|
| Yes | No |

| 20. Do you know the **name** of your **primary care provider**? | |
|---|---|
| Yes | No |

| 21. Do you know **how to contact** the **care coordinator** at your primary care provider's office? | |
|---|---|
| Yes | No |

| 22. Do you know **where to seek treatment** if your provider is unavailable or it is after hours? | |
|---|---|
| Yes | No |

| 23. In the past 3 months, how many times did you go to a hospital **emergency department**? |
|---|
| |

| 24. In the past 3 months, how many times were you **hospitalized** for **one night** or **longer**? |
|---|
| |

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| | | |
|---|---|---|
| 25. Do you have concerns related to **employment** or **unemployment**? | Yes | No |
| 26. Are your **medical bills** challenging for you to manage? | Yes | No |
| 27. Do you have **obstacles** related to **housing**? | Yes | No |
| 28. Can you identify a **reliable support system?** | Yes | No |
| 29. Do you **feel** like you have **purpose** in your life? | Yes | No |
| 30. Do you **have** or **know** of a source of **reliable transportation**? | Yes | No |
| 31. Do you have a difficult time **getting an appointment** with your provider? | Yes | No |
| 32. Do you feel like you have **adequate** health insurance **coverage**? | Yes | No |
| 33. Do you have **needs regarding food** and/or access to healthy food options? | Yes | No |
| 34. Do you know the **best food choices** for your health, diagnosis and diet? | Yes | No |
| 35. Do you know what **health signs** you should **monitor at home**? | Yes | No |

| 36. Do you know of any **changes** you could make to **improve the quality** of your health? | |
|---|---|
| Yes | No |

| 37. Do you intend to **take action** in the **next 3 months** to improve your heath? | |
|---|---|
| Yes | No |

38. List at least **<u>3 things</u>** you would like to achieve **in the next 3 months** to increase your quality of life and your physical and/or mental health:

_____

_____

_____

_____

_____

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39. Should you ever be unable to communicate, do you have **a written statement of your wishes** regarding medical treatment ? (circle all that apply)

| | | | | |
|---|---|---|---|---|
| No-Nothing | Yes -Living Will | Yes –Power of Attorney | Yes –DNR | Yes-Five Wishes |

40. **Circle** all **up to date** immunizations:

| | | | | |
|---|---|---|---|---|
| None | Flu | Pneumonia | Shingles | Tetanus |

41. **Circle** all **up to date** screenings:

| | | | | |
|---|---|---|---|---|
| None | Colon Cancer | Breast Cancer | Osteoporosis | Other |

42. **Circle** any of the following **community resources** that you **have used** or **currently use:**

| | | |
|---|---|---|
| Meals on Wheels | Pathways Treatment Center | Office of Public Assistance |
| Flathead Community Health Center | Eagle Transportation | Shepherd's Hand |
| Western Montana Mental Health | Sunburst Mental Health | Addus Home Care |
| VA | Food Bank | Comfort Keepers |
| Samaritan House | Adult Protective Services | Flathead Choice Home Health |
| United Way | Community Action Partnership | Loyal Care In-Home Assistance |
| Agency on Aging | Love Inc. | Addiction Treatment |
| Home Options | Faith-Based Services | A Ray of Hope |
| Summit Independent Living | A Plus Health Care | Salvation Army |
| Grocery Delivery Service | Agape Home Care | Montana Center for Wellness and Pain |
| The Newman Center | ASSIST | Low Income Energy Assistance |
| Flathead Chemical Dependency | Free Meals | Blind and Low Vision |
| Sunburst 'Village' | The Lamplighter House | Embrace Health |
| North Valley Hospital | PACT | The Summit Medical Fitness Center |
| | Neighbors in Need | Other/Not Listed |

By signing below, I agree that this information may be shared with professionals who have been, are currently, or will be involved with my care.

Signature: _____ Date: _____

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