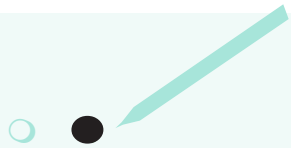
of Tennessee

Reference #:

TN Division of Health Care Finance & Administration | CoverKids

kidcentral tn KIDCENTRALTN.COM

Health Needs Survey



- ***Please fill in your responses like this using ONLY A BLUE OR BLACK PEN.***
- ***Do NOT use GREEN INK.***
- ***Please answer as many questions as you can.***

Leave blank the question(s) you cannot or choose not to answer.

Demographic Information

Name: _____

Address: _____

_____

Date of Birth: ☐☐ ☐☐ ☐☐☐☐ (MM DD YYYY)

What is your gender? ○ **Male** ○ **Female**

Phone number: _____

Why are we doing this?

We want to provide you with high quality care that meets your needs. To do this, we need some information from you.

The information you provide us will be kept private. The information may be shared with members of your care team (primary care provider, specialists and case manager, if needed).

Your answers will be used to help us give you the best information and service possible. Please complete and return this survey.

Notice: Completion of this form is considered an approval to utilize the information, as needed, to best coordinate your care.

We use race, language and ethnic background to improve the quality of treatment and care that you need. We also use it to develop programs specific for you.

1. Which of these best describes your race?

○ American Indian/Alaskan Native ○ Asian ○ Black/African American
○ Native Hawaiian/Other Pacific Islander ○ White ○ Declined

2. Do you consider yourself Hispanic/Latino?

○ Yes ○ No ○ Declined ○ Unavailable/Unknown

3. What language do you speak? _____

Reference #:

Health History

4. Compared to others your age, how would you describe your overall health?

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

5. Do you have any of the special needs or disabilities listed below?

○ Hearing Impairment ○ Deaf ○ Vision Impairment
○ Blind ○ Learning Disability ○ None

6. How much do you weigh in pounds?

Pounds		
	0	0
100	10	1
200	20	2
300	30	3
400	40	4
500	50	5
600	60	6
700	70	7
	80	8
	90	9

7. How tall are you?

Feet	Inches
	0
	1
2	2
3	3
4	4
5	5
6	6
7	7
	8
	9
	10
	11

8. How often do you need to have someone help you read instructions, pamphlets or other written material from your doctor or pharmacy?

○ Never ○ Rarely ○ Sometimes ○ Often ○ Always

Health History *(continued)*

Please tell us about your medical conditions

9. Has a doctor or other health care professional ever told you that you have any of the following?

Check all that apply

Asthma	Yes	No
Bipolar Disorder or mood swings	Yes	No
Cancer	Yes	No
Chronic Obstructive Pulmonary Disease (COPD) or other breathing problems	Yes	No
Diabetes or Sugar in Your Blood	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
High Cholesterol	Yes	No
HIV or AIDS	Yes	No
Major Depression or feeling sad most of the time	Yes	No
Obesity or that you are overweight	Yes	No
Schizophrenia	Yes	No
Sickle Cell Disease	Yes	No
You might need a transplant	Yes	No

10. How many medications do you take each day? (include prescription and over-the-counter)

None 1 to 3 4 to 7 8 to 11 11 or more

11. In the last three months, how often have you taken medications differently than they were prescribed?

Daily Almost every day Sometimes Never

12. In the last three months, how often have you used medications not prescribed to you?

Daily Almost every day Sometimes Never

13. Has your health caused you to miss time away from school, work or other activities within the last year?

Yes No

Health History *(continued)*

14. In the past 12 months, how many times have you:

Gone to the Emergency Room?

○ None ○ 1 to 2 ○ 3 to 5 ○ 6 or more

Stayed overnight in a hospital?

○ None ○ 1 to 2 ○ 3 to 5 ○ 6 or more

15. Over the last 2 weeks, how often have you been bothered by any of the following?

Feeling sad, down, depressed or hopeless

○ Not at all ○ Several Days ○ More than half the days ○ Nearly every day

Having little or no pleasure in doing things

○ Not at all ○ Several Days ○ More than half the days ○ Nearly every day

Feeling nervous, anxious or on edge?

○ Not at all ○ Several Days ○ More than half the days ○ Nearly every day

Not being able to stop or control worrying?

○ Not at all ○ Several Days ○ More than half the days ○ Nearly every day

16. When was the last time that you had a colonoscopy?

○ Never ○ Within the last 10 years ○ More than 10 years

For women only, otherwise skip to question 20.

17. Are you pregnant?

○ Yes ○ No

If no, are you planning to get pregnant in the next 12 months?

○ Yes ○ No

If yes, how long have you been pregnant?

○ 1 to 3 months ○ 4 to 6 months ○ 7 to 9 months

18. When was the last time you had a mammogram?

○ Never ○ Within the last 2 years ○ More than 2 years ○ I have had a mastectomy

19. When was the last time you had a Pap Smear?

○ Never ○ Within the last 3 years ○ More than 3 years ○ I have had a hysterectomy

Health History *(continued)*

Please tell us about some of your daily habits

20. Have you had a flu or pneumonia vaccine in the last year?

- ○ Yes
- ○ No

21. How often do you walk, run or do other exercises for 30 minutes a day that make you breathe heavier or make your heart beat faster?

- ○ Less than 1 time per week
- ○ 1 to 2 times per week
- ○ 3 times per week
- ○ 4 times per week
- ○ 5 or more times per week

22. Do you currently use tobacco products (cigarettes, chewing tobacco, cigars, pipes)?

- ○ Yes, I currently use tobacco products

  (For tobacco users only) In the last year, how many times have you quit using tobacco products for at least 24 hours? _____

  (For tobacco users only) Are you seriously thinking of quitting tobacco use?
  - ○ *Yes, within the next 30 days*
  - ○ *Yes, within the next 6 months*
  - ○ *No, not thinking of quitting*

- ○ No, I quit within the last 6 months
- ○ No, I quit more than 6 months agot
- ○ No, I have never used tobacco products

23. How often do you use alcohol, drugs or medications which affect your mood or help you relax?

- ○ Daily ○ Almost every day ○ Sometimes ○ Rarely or never

If the response is daily or almost every day only:

Have you felt you ought to cut down on your drinking or drug use?
- ○ *Yes* ○ *No*

Have people annoyed you by criticizing your drinking or drug use?
- ○ *Yes* ○ *No*

Have you felt bad or guilty about your drinking or drug use?
- ○ *Yes* ○ *No*

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)
- ○ *Yes* ○ *No*

Health History *(continued)*

24. Are you interested in making changes in any of the following areas? *Check all that apply.*

Controlling your use of alcohol or drugs

- ○ Somewhat interested
- ○ Very interested

Healthy eating

- ○ Somewhat interested
- ○ Very interested

Exercising or increasing physical activity

- ○ Somewhat interested
- ○ Very interested

Managing stress

- ○ Somewhat interested
- ○ Very interested

Smoking or chewing tobacco

- ○ Somewhat interested
- ○ Very interested

Getting to or maintaining a healthy weight

- ○ Somewhat interested
- ○ Very interested
- ○ I am not interested in making any changes at this time.

Thank you for allowing us to learn more about you. We will use this information to help you live healthier.

Do you need help in these languages: العربية (Arabic); Bosanski (Bosnian); کوردی – بادینانی (Kurdish-Badinani); کوردی – سۆرانی (Kurdish- Sorani); Soomaali (Somali); Español (Spanish); Ngươi Việt (Vietnamese)

CoverKids language and member services are free at 1-888-325-8386, Monday-Friday, 8 a.m. to 6 p.m. ET. For TDD/ TTY help call 1-866-591-2908. Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, birthplace, or disability. Need help? Call the Office of Non-Discrimination Compliance for free at 1-855-286-9085. For TTY dial 711 and ask for 855-286-9085

of Tennessee

1 Cameron Hill Circle | Chattanooga, TN 37402

bcbst.com

15CKD2058 (8/15)