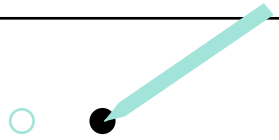
Reference #:

TN Division of TennCare | CoverKids

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

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 in the postage-paid envelope that has been provided.

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
○ Hispanic/Latino
○ I don't know
○ Declined

2. Do you consider yourself Hispanic/Latino?

○ Yes ○ No ○ I don't know ○ Declined

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
- ○ I don't know
- ○ Declined

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

- ○ Hearing Impairment
- ○ Deaf
- ○ Vision Impairment
- ○ Blind
- ○ Learning Disability
- ○ None
- ○ I don't know
- ○ Declined

6. How much do you weigh in pounds?

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

- ○ I don't know
- ○ Declined

7. How tall are you?

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

- ○ I don't know
- ○ Declined

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
- ○ I don't know
- ○ Declined

Reference #:

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 ○ 12 or more
○ I don't know ○ Declined

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

○ Daily ○ Almost every day ○ Sometimes ○ Never
○ I don't know ○ Declined

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

○ Daily ○ Almost every day ○ Sometimes ○ Never
○ I don't know ○ Declined

Health History (continued)

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

○ Yes ○ No ○ I don't know ○ Declined

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 ○ I don't know ○ Declined

Stayed overnight in a hospital?

○ None ○ 1 to 2 ○ 3 to 5 ○ 6 or more ○ I don't know ○ Declined

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
○ I don't know ○ Declined

Having little or no pleasure in doing things

○ Not at all ○ Several Days ○ More than half the days ○ Nearly every day
○ I don't know ○ Declined

Feeling nervous, anxious or on edge?

○ Not at all ○ Several Days ○ More than half the days ○ Nearly every day
○ I don't know ○ Declined

Not being able to stop or control worrying?

○ Not at all ○ Several Days ○ More than half the days ○ Nearly every day
○ I don't know ○ Declined

16. What is the level of stress in your everyday life?

○ Very high ○ High ○ Medium ○ Low ○ Other
○ I don't know ○ Declined

17. How do you manage the day-to-day stress in your life?

○ I don't have any stress in my life
○ I try to relax or manage stress myself
○ I am taking medications to manage my stress
○ Other
○ Declined
○ I have stress in my life, but I can't seem to do anything about it
○ I am getting help from a professional
○ I am using alcohol to manage my stress
○ I don't know

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

○ Never ○ Within the last 10 years ○ More than 10 years
○ I don't know ○ Declined

Health History (continued)

For women only, otherwise skip to question 22.

19. Are you pregnant?

○ Yes ○ No ○ I don't know ○ Declined

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

○ Yes ○ No ○ I don't know ○ Declined

If yes, how long have you been pregnant?

○ 1 to 3 months ○ 4 to 6 months ○ 7 to 9 months ○ I don't know ○ Declined

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

○ Never ○ Within the last 2 years ○ More than 2 years ○ I have had a mastectomy
○ I don't know ○ Declined

21. 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
○ I don't know ○ Declined

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

○ Yes ○ No ○ I don't know ○ Declined

Please tell us about some of your daily habits

23. 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 ○ I don't know ○ Declined

24. How many servings of fruit do you consume in a typical day?

○ 6 servings or more ○ 4-5 servings ○ 3 servings ○ 2 servings
○ 1 serving ○ Less than 1 serving ○ None ○ I don't know
○ Declined

Health History (continued)

25. How many servings of vegetables do you consume in a typical day?

- ○ 7 servings or more
- ○ 5-6 servings
- ○ 4 servings
- ○ 3 servings
- ○ 2 servings
- ○ 1 serving
- ○ Less than 1 serving
- ○ None
- ○ I don't know
- ○ Declined

26. 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 ago
- ○ No, I have never used tobacco products
- ○ I don't know
- ○ Declined

27. 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
- ○ I don't know
- ○ Declined

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)

28. What percent of time do you usually buckle your safety belt when driving or riding?

- ○ Never - 0 percent
- ○ Seldom - 1-39 percent
- ○ Sometimes - 40-79 percent
- ○ Usually - 80-99 percent
- ○ Always - 100 percent
- ○ I don't know
- ○ Declined

29. If you ride a bicycle, motorcycle or other motorized vehicle (scooter, four wheeler), how often do you wear a helmet?

- ○ Sometimes or never
- ○ I don't ride any of these motorized vehicles.
- ○ Always or almost always
- ○ I don't know
- ○ Declined

30. 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	○ I don't know	○ Declined
Healthy eating			
○ Somewhat interested	○ Very interested	○ I don't know	○ Declined
Exercising or increasing physical activity			
○ Somewhat interested	○ Very interested	○ I don't know	○ Declined
Managing stress			
○ Somewhat interested	○ Very interested	○ I don't know	○ Declined
Smoking or chewing tobacco			
○ Somewhat interested	○ Very interested	○ I don't know	○ Declined
Getting to or maintaining a healthy weight			
○ Somewhat interested	○ Very interested	○ I don't know	○ Declined

- ○ 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.

Reference #:

Spanish: Español ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-325-8386. (TRS: 711: 1-888-418-0008).

Kurdish: کوردی ئەگەر بە کوردی سۆرانی قسە دەکەن، خزمەتگوزارییەکانی وەرگێڕان بەخۆڕایی دەخرێتە بەردەستتان. پەیوەندی بکەن بە ژمارە 1-888-325-8386 (TRS: 711: 1-888-418-0008) .

Do you need help with your health care, talking with us, or reading what we send you? Call us for free at 1-888-325-8386. We can connect you with the free help or service you need. (For TTY call: 1-866-591-2908)

We obey federal and state civil rights laws. We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. Do you think we did not help you or treated you differently? Then call CoverKids 1-888-325-8386 *(TRS 711) for free.

BlueCare Tennessee

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