

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? _____

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		
	<input type="radio"/> 0	<input type="radio"/> 0
<input type="radio"/> 100	<input type="radio"/> 10	<input type="radio"/> 1
<input type="radio"/> 200	<input type="radio"/> 20	<input type="radio"/> 2
<input type="radio"/> 300	<input type="radio"/> 30	<input type="radio"/> 3
<input type="radio"/> 400	<input type="radio"/> 40	<input type="radio"/> 4
<input type="radio"/> 500	<input type="radio"/> 50	<input type="radio"/> 5
<input type="radio"/> 600	<input type="radio"/> 60	<input type="radio"/> 6
<input type="radio"/> 700	<input type="radio"/> 70	<input type="radio"/> 7
	<input type="radio"/> 80	<input type="radio"/> 8
	<input type="radio"/> 90	<input type="radio"/> 9

- I don't know
 Declined

7. How tall are you?

Feet	Inches
	<input type="radio"/> 0
	<input type="radio"/> 1
<input type="radio"/> 2	<input type="radio"/> 2
<input type="radio"/> 3	<input type="radio"/> 3
<input type="radio"/> 4	<input type="radio"/> 4
<input type="radio"/> 5	<input type="radio"/> 5
<input type="radio"/> 6	<input type="radio"/> 6
<input type="radio"/> 7	<input type="radio"/> 7
	<input type="radio"/> 8
	<input type="radio"/> 9
	<input type="radio"/> 10
	<input type="radio"/> 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

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	<input type="radio"/> Yes	<input type="radio"/> No
Bipolar Disorder or mood swings	<input type="radio"/> Yes	<input type="radio"/> No
Cancer	<input type="radio"/> Yes	<input type="radio"/> No
Chronic Obstructive Pulmonary Disease (COPD) or other breathing problems	<input type="radio"/> Yes	<input type="radio"/> No
Diabetes or Sugar in Your Blood	<input type="radio"/> Yes	<input type="radio"/> No
Heart Disease	<input type="radio"/> Yes	<input type="radio"/> No
High Blood Pressure	<input type="radio"/> Yes	<input type="radio"/> No
High Cholesterol	<input type="radio"/> Yes	<input type="radio"/> No
HIV or AIDS	<input type="radio"/> Yes	<input type="radio"/> No
Major Depression or feeling sad most of the time	<input type="radio"/> Yes	<input type="radio"/> No
Obesity or that you are overweight	<input type="radio"/> Yes	<input type="radio"/> No
Schizophrenia	<input type="radio"/> Yes	<input type="radio"/> No
Sickle Cell Disease	<input type="radio"/> Yes	<input type="radio"/> No
You might need a transplant	<input type="radio"/> Yes	<input type="radio"/> 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 have stress in my life, but I can't seem to do anything about it
 I try to relax or manage stress myself I am getting help from a professional
 I am taking medications to manage my stress I am using alcohol to manage my stress
 Other I don't know
 Declined

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.**

Spanish: Español ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al BlueCare 1-800-468-9698. Llame al TennCareSelect 1-800-263-5479 (TTY: 711: 888-418-0008).

Kurdish: کوردی

ئاگاداری: ئهگهر به زمانی کوردی قهسه دهکهیت، خزمهتگوزاریهکانی یارمتهی زمان، بهخواری، بو تو بهرهسته. پهیهندی به بکه

(TTY: 711: 888-418-0008), TennCareSelect 1-800-263-5479, BlueCare 1-800-468-9698



Do you need help with your health care, talking with us, or reading what we send you? Call us for free at: BlueCare 1-800-468-9698 or TennCareSelect 1-800-263-5479 (TTY: 711 and ask for 888-418-0008).

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 BlueCare 1-800-468-9698, TennCareSelect 1-800-263-5479 or TennCare 1-855-857-1673 (TRS 711) for free.

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