Patient Name: _____ Date of birth: _____

Preferred language: _____ Do you have health insurance? Yes ☐ No ☐

Education and Employment

What is the highest level of education you have finished?

☐ Still in school	☐ 7th grade	☐ 1 yr college
☐ 1st grade	☐ 8th grade	☐ 2 yrs college
☐ 2nd grade	☐ 9th grade	☐ 3 yrs college
☐ 3rd grade	☐ 10th grade	☐ 4 yrs college
☐ 4th grade	☐ 11th grade	☐ >4 yrs college
☐ 5th grade	☐ 12th grade	
☐ 6th grade	☐ GED	☐ Decline to answer

Are you employed? Yes ☐ No ☐ If **No**, are you looking for work? Yes ☐ No ☐

If **yes**, your current work situation: Full-time ☐ Part-time ☐ Per Diem ☐

Medical History

Do you see your doctor at least once per year for a physical or well care visit? Yes ☐ No ☐

Have you had an emergency room (ER) visit in the last 3 months? Yes ☐ No ☐

If yes, what was the reason for the ER visit? _____

Housing and Transportation

What is your housing situation today?

☐ Own	☐ Double-up	☐ Other/ SRO room
☐ Rent	☐ Street	☐ Unknown
☐ Shelter	☐ Transitional/Treatment Center	☐ Decline to answer

Are you worried about losing your housing? Yes ☐ No ☐

In the PAST YEAR, have you or any family members you live with been unable to get any of the following when it was needed:

Food Yes ☐ No ☐	Clothing Yes ☐ No ☐	Phone Yes ☐ No ☐
Utilities Yes ☐ No ☐	Childcare Yes ☐ No ☐	Legal services Yes ☐ No ☐

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Other, describe _____

Has lack of transportation kept you from going to medical appointments, meetings, work, or getting things you need daily?
Yes ☐ No ☐

Legal Services

Do you have any legal issues that are getting in the way of your health, healthcare, or general wellbeing? Yes ☐ No ☐
What areas are most impacted?

☐ Housing	☐ Employment	☐ Family
☐ Financial	☐ Transportation	☐ Healthcare

Other, describe _____

Function Status

Have you or any of your family members noticed changes in your memory, language, or ability to complete routine tasks?
Yes ☐ No ☐_____

Do you have difficulties with walking or with your balance? Yes ☐ No ☐

Are you able to do the following activities by yourself or do you need help- bathing, dressing, going to the bathroom, feeding?
By myself ☐ Need help ☐

Are you able to do the following activities by yourself or do you need help?

Shopping	By myself ☐	Need help ☐
Transportation	By myself ☐	Need help ☐
Laundry	By myself ☐	Need help ☐
Light housework	By myself ☐	Need help ☐
Light meal preparation	By myself ☐	Need help ☐
Managing finances	By myself ☐	Need help ☐
Using the telephone	By myself ☐	Need help ☐
Taking medications	By myself ☐	Need help ☐

SBIRT (Screening, Brief Intervention and Referral to Treatment)

In the PAST YEAR, how often have you used the following?

Alcohol- 4 OR MORE DRINKS IN 1 DAY		Tobacco products, including Smokeless, or vape	
Never ☐	Quit within year ☐	Never ☐	Quit withing year ☐
Once or twice ☐	Monthly ☐	Once or twice ☐	Monthly ☐
Weekly ☐	Daily, almost daily ☐	Weekly ☐	Daily, almost daily ☐

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Prescription Drugs, for non-medical reasons				Illegal Drugs			
Never	☐	Quit within year	☐	Never	☐	Quit withing year	☐
Once or twice	☐	Monthly	☐	Once or twice	☐	Monthly	☐
Weekly	☐	Daily, almost daily	☐	Weekly	☐	Daily, almost daily	☐

Tobacco Screening

Current every day smoker _____
Current some day smoker _____
Former smoker _____
Never smoker _____
Unknown if ever smoked _____
Smoker- current status unknown _____

Do you vape? Yes ☐ No ☐
Do you use smokeless tobacco? Yes ☐ No ☐

cigarettes per day _____

How many years been smoking? _____

PHQ-2

Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?

Not at all: **0** Some Days: **1** Most Days: **2** Nearly Every Day: **3**

Little interest or pleasure in doing things: _____ (write the number that corresponds to your answer)
Feeling down, depressed, or hopeless: _____ (write the number that corresponds to your answer)

Current Violence Assessment

Are you CURRENTLY concerned about your safety at home or with others? Yes ☐ No ☐

Type of violence:
Emotional _____
Physical _____
Sexual _____

By:
Spouse _____
Partner _____
Child _____

Past Violence Assessment

In the PAST, were you ever concerned about your safety at home or with others? Yes ☐ No ☐

Type of violence:
Emotional _____
Physical _____
Sexual _____

By:
Spouse _____
Partner _____
Child _____

Last Revised: 3/30/2023