Client Assessment Tool

Demographics			
DI1	What is your race/ethnicity? Caucasian Hispanic/Latino Native American African American Asian American Asian/Pacific Islander Caribbean Other	Single select	
DI1	[Caribbean, African, Other] Specify country	Free text	
DI2	What languages do you speak? English Spanish Other	Multi-select	
DI2	[Other] What language do you speak	Free text	
DI3	What is your marital status? Single Married Divorced Separated Domestic partnership	Single select	
DI3	[Single] Committed relationship Widowed	Free text	
DI4	What is your gender identification?	Free text	
DI5	What is you r sexual orientation?	Free text	
DI6	Are you a veteran?	Yes/No	
DI7	Please indicate client's level of educational attainment Elementary High School College Graduate School GED Other	Single select	Elementary Id
DI7	[Other] Educational attainment	Free text	
DI8	Are you currently a student?	Yes/No	
DI8	[Yes] What is your course of study and when do you expect to complete your course of study?	Free text	
DI9	Indicate client's employment status Employed Unemployed Job Training Disabled	Single select	
DI9	[Employed] Part time Full time	Single select	
DI9	[Employed] Enter the Employer, Type of Work, Address & Phone and whether the client can be contacted?	Free text	
DI9	[Job training] Enter the Agency, Type of Training, Address & Phone and whether the client to be contacted?		

Social Supports		
DI10	What is the name of your current spouse or partner?	Free text
DI11	Spouse or partner's medical status	Free text
DI12	Is your spouse/partner aware of your medical status?	Yes/No
DI13	Do you have any children/dependents?	Yes/No
DI13	List the name, relationship, age living at home, health status and active	
DI14	Do you have guardianship arrangements made for the children/dependents?	Yes/No
DI14	List the name, relationship, address and phone number	Free text
DI15	List individuals who you would identify as part of your support system. List the names, relationship and whether they are aware of the client's medical status	Free text
DI16	In general, would you describe your support system as Excellent Very Good Good Fair Poor	Single select
DI17	Is religion/spirituality considered a support for client?	Yes/No
DI18	What is your religious affiliation?	Free text
DI19	What are your interests and hobbies	Free text
DI20	Are you involved in community activities/organizations?	Yes/No
DI20	[No] Are you interested in becoming involved with community activities/organizations?	Yes/No

Health Status		
HS11	In general, would you say your health is? Excellent Very Good Good Fair Poor	Yes/No
HS12	What is your current height (self-reported or from record)	numeric
HS12	What is your current weight (self-reported or from record)	numeric
HS12	BMI	calculation
HS13	Do you know what your average blood pressure is?	Yes/No
HS13	Blood pressure (actual)	
Receipt of Care		
HS14	Are you currently receiving outpatient medical care?	Yes/No
HS15	Do you currently have medical insurance?	Yes/No
HS15	[Yes] what type of insurance do you have? Medicaid/Priority Partners Medicare Medicare Savings Program Prescription Coverage Other:	Single select
HS15	[Other] What is the other insurance?	Free text
	Where you go to get your medical care? Hospital/Health Clinic PCP Address Phone /fax Hospital/Health Clinic Specialist Address Phone /fax Hospital/Health Clinic Vision Address Phone /fax Hospital/Health Clinic Dental Address Phone /fax Hospital/Health Clinic	Free text (fill in the blank
	Behavioral Health Address Phone /fax Hospital/Health Clinic Other Address Phone /fax	
HS17	Do you have trouble making appointments?	Yes/No
HS18	Do you feel that you can communicate effectively with your provider?	Yes/No
HS18	Is there a release of information for the primary care provider?	Yes/No
HS18	[Yes]Date release expires:	Free text
HS20	What have been the reasons for your ED visits? (List all reasons)	Free text
HS21	Do you have any allergies	Yes/No
HS21	[YES] List allergies	
HS22	List vaccination history	Fill in the blanks
	Influenza Pneumonia TD/TDAP Shingles Other Enter date received and re-vax date	
	[Other]	Free text
HS23	Is there a need for any vaccinations?	

HS24	Have you been screened for Tuberculosis?	Yes/No
HS24	Tuberculosis last screen date	Date
HS24	Tuberculosis result Positive Negative	Single select
HS24	[Positive] Active Inactive	Single select
HS25	Have you been screened for Hepatitis C?	Yes/No
HS25	Hepatitis C last screen date	Date
HS25	Hepatitis C result Positive Negative	Single select
HS25	[Positive] Active Inactive	Single select
HS26	Does the client have a history of STIs?	Yes/No
	List the STI, date of diagnosis and whether treatment was received	Free text
HS27	Are you currently receiving care from an OB/GYN or Urologist?	Yes/No
HS28	Number of pregnancies	numeric
HS29	Number of living children	numeric
HS30	Method of contraception	Free text
HS31	Are you currently receiving dental care	Yes/No
HS32	[No] Is dental care needed?	Yes/No
HS33	Are you currently receiving vision care?	Yes/No
HS34	[No] Is vision care needed?	Yes/No
HS35	Do you have trouble seeing things far away (such as the TV across the room or seeing friends across the street)?	Yes/No
HS36	Do you have trouble seeing things up close (such as the newspaper)?	Yes/No
HS37	Do you ever find it helpful to use something that helps you see?	Yes/No
HS37	Do you ever find it helpful to use something that helps you see such as? Glasses Contacts Magnifying glass Other	Multi-select
HS37	[Other]	Free text
HS38	Do you have trouble hearing?	Yes/No
HS38	[Yes] do you want to see a provider about hearing?	Yes/No
HS39	How would you describe your appetite? Good Fair Poor	Single select
HS40	Have you noticed any changes with your weight?	Yes/No
HS40	[Yes] Intentional weight loss Intentional weight gain Unintentional weight loss Unintentional weight	Single select
HS40	Pounds lost or gained	Numeric
HS41	Does the client have any dietary concerns?	Yes/No
HS41	[Yes] What are the dietary concerns	Free text
HS42	Are you taking any dietary supplements?	Yes/No
HS42	[Yes] Describe	Free text
HS43	On average, how many times do you eat fast food? 0 – 1 times per week 2 – 3 times per week 4 – 5 times per week 6 – 7 times per week	Single select
HS44	How many times a day do you eat meals?	Free text
HS44	How many times a day do you eat snacks?	Free text
HS45	Do you ever skip meals?	Yes/No
HS45	[Yes] Which meals do you skip? Breakfast Lunch Dinner	Muti-select
HS46	Do you have trouble maintaining food in the house?	Yes/No
HS46	[Yes] when does this happen and what do you do?	Free text
HS47	Does anyone assist you with maintaining food?	Yes/No
Medication History and Adherence		
MHA3	Are you taking any over the counter medicine, including supplements and herbal medicine?	Yes/No
	[Yes] List the over the counter medicine, including supplements and herbal medicine	Free text
MHA4	Are you enrolled in Medicare Part D?	Yes/No
	[Yes] Do you have your card with you? (If yes, make a copy. If no, call the member later for the Part D	Yes/No

	number)	
MHA5	Does anyone assist you with taking your medicines?	Yes/No
	[Yes] Who assists you with taking your medicines? (Add friend / family member(s) to the demographic information on contact page)	Free text
MHA6	Do you have trouble reading your medicine bottle or instructions?	Yes/No
MHA7	How many times a week or month do you have to go to the pharmacy to get medication?	Free text
MHA8	Do you use any of the following to help with your medications? Mail delivery (e.g. MedCo) Bubble packs Pill boxes	Multi-select
MHA9	How many times a week do you miss taking your medicine(s)? 0 >0	Single select
MHA11	[>0] Do you ever miss you medication(s) because you...? Forget Felt worse or had side effects Forget to take medication with you when you're not at home Take too many pills per day Don't think you need medicine Don't think the medicine helps Run out Have difficulty affording your medication Can't get to the pharmacy Can't find a doctor to prescribe it Use more than prescribed	Multi-select
MHA10	How many times a year do you run out of your medicine(s) for a least a day or two? 0 >0	Single select
MHA11	[>0] Do you ever miss you medication(s) because you...? Forget Felt worse or had side effects Forget to take medication with you when you're not at home Take too many pills per day Don't think you need medicine Don't think the medicine helps Run out Have difficulty affording your medication Can't get to the pharmacy Can't find a doctor to prescribe it Use more than prescribed	Multi-select
HS48	Are you currently participating in any clinical trials?	Yes/No
	[Yes] What is the nature of trial, sponsor, time and location?	Free text
HS49	Are you using complementary/alternative medicine?	Yes/No
	[Yes] Describe treatments being used	Free text
	[No] Are you interested in complementary/alternative medicine?	Free text
HS50	Are there any other health issues or concerns?	Yes/No
	[Yes] Describe	Free text
Emotional Health Depression		
BH1	Does the client know where he/she is?	Yes/No
BH1	Does the client know what the date is?	Yes/No
BH1	Does the client know why he/she is here (or why you are seeing him/her)	Yes/No
BH2	Are you currently in treatment for any emotional, behavioral, or mental health issue?	Yes/No
BH2	[Yes] List the clinician, program, address and phone/fax	Free text
BH3	Are any of the medications that we reviewed for any emotional, behavioral, or mental health issues?	Yes/No
BH3	[Yes] List medications, including reason for medication and low long the client has taken the medication	Free text
BH4	Over the last two weeks, how often have you been bothered by little interest or pleasure in doing things? Not at all Several days More than half of the days Nearly every day	Single select
BH4	Over the last two weeks, how often have you been bothered by feeling down, depressed or hopeless? Not at all Several days More than half of the days Nearly every day	Single select
	If the sum of the 2 previous questions is 3 or more refer to a case manager to complete the remainder of the assessment	
Substance Use		
SU1	Describe tobacco use Currently everyday Currently some days Former Never Smoke exposure	Single select

SU2	[Currently every day and currently some days] Are you willing to give quitting a try? Yes No Not sure	Single select
SU3	Do you have a history or diagnosis for substances or alcohol dependence?	Yes/No
SU4	Have you received treatment for alcohol/drug use?	Yes/No
SU5	[Yes] Is this treatment current or did the treatment happen in the past? Current Past	Multi-select
SU5	List the program, whether it's past or current and the type of treatment	Free Text
SU6	In the past year, have you used the following? Alcohol Prescription drugs for non-medical reasons (including opioids, benzodiazepines Illegal drug: marijuana Illegal drug: cocaine Illegal drug: crack Illegal drug: heroin Illegal drug: ecstasy Illegal drug: other	Multi select
SU6	How often have you used alcohol in the past year? Once or twice Monthly Weekly Daily or almost daily	Single select
SU6	How often have you used prescription drugs for non-medical reasons (including opioids, benzodiazepines) in the past year? Once or twice Monthly Weekly Daily or almost daily	
SU6	How often have you used marijuana in the past year? Once or twice Monthly Weekly Daily or almost daily	
SU6	How often have you used cocaine in the past year? Once or twice Monthly Weekly Daily or almost daily	
SU6	How often have you used heroin in the past year? Once or twice Monthly Weekly Daily or almost daily	
SU6	How often have you used crack in the past year? Once or twice Monthly Weekly Daily or almost daily	
SU6	How often have you used ecstasy in the past year? Once or twice Monthly Weekly Daily or almost daily	
SU6	What other substance did you use and how often have you used it in the past year?	Free text
SU7	In the past 3 months have you used the following? Alcohol Prescription drugs for non-medical reasons (including opioids, benzodiazepines Illegal drug: marijuana Illegal drug: cocaine Illegal drug: crack Illegal drug: heroin Illegal drug: ecstasy Illegal drug: other	
SU7	How often have you used alcohol in the past 3 months? Once or twice Monthly Weekly Daily or almost daily	
SU7	How often have you used prescription drugs for non-medical reasons (including opioids, benzodiazepines) in the past 3 months? Once or twice Monthly Weekly Daily or almost daily	
SU7	How often have you used marijuana in the past 3 months? Once or twice Monthly Weekly Daily or almost daily	
SU7	How often have you used cocaine in the past 3 months? Once or twice Monthly Weekly Daily or almost daily	
SU7	How often have you used heroin in the past 3 months? Once or twice Monthly Weekly Daily or almost daily	

SU7	How often have you used crack in the past 3 months? Once or twice Monthly Weekly Daily or almost daily	
SU7	How often have you used heroin in the past 3 months? Once or twice Monthly Weekly Daily or almost daily	
SU7	How often have you used ecstasy in the past 3 months? Once or twice Monthly Weekly Daily or almost daily	
SU7	What other substance did you use and how often have you used it in the past 3 months?	
SU8	Have you ever used any drug by injection (for non-medical use)? Never Yes, in the last 3 months No, not in the last 3 months	
Activities of Daily Living		
	Aare you able to complete the following task(s) by yourself, or do you require assistance?	
	Eating By self Some assistance Total assistance	Single select
	Ambulating By self Some assistance Total assistance	
	Transferring By self Some assistance Total assistance	
	Grooming By self Some assistance Total assistance	
	Dressing	
	By self Some assistance Total assistance	
	Bathing By self Some assistance Total assistance	
	Toileting By self Some assistance Total assistance	
	Homemaking By self Some assistance Total assistance	
	Grocery shopping By self Some assistance Total assistance	
	Financial management By self Some assistance Total assistance	
	Transportation By self Some assistance Total assistance	
	Laundry By self Some assistance Total assistance	
	Decision making By self Some assistance Total assistance	
	Who assists with these tasks?	
	Additional comments/discussion	
Needs and Assets Assessment		
	Do you need help with transportation to get you medical appointments?	Yes/No
	[Yes] What type of assistance/help do you need?	
	[Yes] How frequently will you need help with transportation?	

Financial Resources (Sources of Income)					
NAA3	Source	Applied (yes/no)	Approved or Denied	Amount Received	
	ADAP				
	ADAP Insurance				
	Alimony				
	Child support				
	Energy Assistance				
	Food Stamps				
	Health Insurance				
	High Risk Insurance Pool				
	Housing Assistance				
	Job Wages				
	Medicaid/Pharmacy Assistance				
	Medicare				
	Public Assistance				
	SSDI				
	SSI				
	Unemployment				
	Veterans Benefit				
	Workers Compensation				
	Other				
NAA4	What is your total monthly income?				
NAA5	Altogether, what is you total monthly household income?				
NAA6	Altogether, about how much outstanding debt do you have?				
Housing					
	What is your current housing situation Group home Live with family and/or friends Own home Rent an apartment or home Scattered site housing Shelter Single room occupancy Other				
	[Other]				
	What is your monthly housing cost?				
	Are you satisfied with your current living situation?				
	Are your utilities working?				
	[No] Describe:				
	Are all your major appliances working?				
	[No] Describe:				
	Do you have an accessible phone in your home?				
	[No] Describe:				
	Do you have any safety concerns?				
	[Yes] Describe:				
	Identify any other /all concerns:				
Legal					
	Are you currently on parole or probation?				
	[Yes] Provide name of probation officer visit dates and contact information:				
	Do you have, or need, assistance with any of the following:				
	Advance directives Has In need				
	Immigration				

	Has In need
	Describe the status of immigration
	Child guardianship Has In need
	Describe the status of child guardianship
	Standby guardianship Has In need
	Describe the status of standby guardianship
	Do you have, or need, assistance with any other legal needs?
	[Yes] Describe
Overall Assessment/Summary	
	Provide a brief summary of the client's status, integrating the above information and observation of your client. client is coping with the present situation.
	List 3 priority areas the client identified to work on to improve their health that will reduce emergency departme hospital readmission.
	1.
	2.
	3.
	Summary Checklist of Needs Activities of daily Living Alcohol/Drug Use Allergies Behavioral health Blood pressure Children/Dependents Complementary and alternative medicine Dental care Educational attainment Employment status Financial resources Health issues or concerns Height, weight and BMI Housing Legal Nutritional care OB/GYN care Receipt of care Social supports STI's Substance abuse Tobacco use Transportation Vaccinations Vision care Other
	[Other] Describe the other need
Client Contact	
	Date assessment started
	Date assessment completed:
	Date of face to face encounter
	Indicate the agreed upon intervals of regular contact: Weekly Biweekly Monthly Every 3 months Other
	[Other] Describe other interval
	CHW name and signature
	Supervisor name and signature