

Primary Caregiver: [text box]

Primary Language: [dropdown menu]

Need for an Interpreter?

- Yes
No

New To Pcp:

- Yes
No

New To Health Center?

- Yes
No

If yes, have you scheduled an initial appointment yet?

- Yes
No

HEALTH / MEDICAL CONDITIONS

What do you/your child usually go to the doctors for?

- Neurological Problem
Musculoskeletal Problems
Chronic Pain
Cardiovascular Problem
Respiratory
Gastrointestinal
Integumentary
Endocrine
Genitourinary
Hematological/Immunologica
Cancer
Cognitive
Growth/Nutritional problem
Sensory deficit
Severe Allergies
Tobacco use
Mental Health/Behavioral issues (past/present)
Substance Abuse Issues

Premature/Sick newborn

- Yes If yes, gestational age: [text box] (in weeks)
No

Pregnant?

- Yes
No

Pregnant EDC [text box]

Comments [text box]

PRIMARY, SPECIALTY, and BEHAVIORAL HEALTH CARE

When was your/child's last physical exam/visit to PCP? [text box] (mm/dd/yyyy)

Are your/child's immunizations up to date?

- Yes
No

Do you/your child see another doctor or health care provider (other than PCP) on a regular basis?

- Yes
No

What kind of provider? [text box]

Medical Specialist Names: [text box]

Mental Health Provider: [text box]

Substance Abuse Provider: [text box]

MEDICATIONS

Do you/your child need or use any prescribed medications?

- Yes
No

If yes, list here: [text box]

Do you/your child use any over-the-counter medications (including herbs, vitamins, etc.)?

- Yes
No

If yes, list here: [text box]

Comments: [text box]

FUNCTIONAL / ADL, IADL

Are you/is your child limited or prevented from doing things that most people of the same age can do?

- Yes
No

If yes, explain: [text box]

Do you/your child need assistance with any of the following:

- Ambulating
Bathing
Dressing
Toileting
Transferring
Eating
Shopping
Meal preparation
Housekeeping
Transportation
Medication Management
Managing Finances

Do you/does your child participate in regular physical activity?

- Yes
No

For child: How many hours per day does your child spend watching TV and/or playing video/computer games: [text box]

MEDICAL EQUIPMENT / SUPPLIES

Do you/does your child need or use any special medical equipment/supplies?

- Yes
No

If yes, select equipment/supplies here:

Mobility Equipment: Cane [Uses Needs] Crutches [Uses Needs] Walker [Uses Needs] Wheelchair [Uses Needs] / [Owns Rents] Orthotics [Uses Needs] Other - Describe [Uses Needs] / [Owns Rents]

Respiratory Equipment: Oxygen [Uses Needs] / [Owns Rents] Nebulizer [Uses Needs] / [Owns Rents] CPAP [Uses Needs] / [Owns Rents] Peak Flow Meter [Uses Needs] Other - Describe [Uses Needs] / [Owns Rents]

Personal Care Equipment: Hospital Bed [Uses Needs] / [Owns Rents] Commode [Uses Needs] Shower Chair [Uses Needs] Grab Bars [Uses Needs] Urinary Catheter [Uses Needs] Colostomy [Uses Needs] Absorbants [Uses Needs] Diapers [Uses Needs] Other - Describe [Uses Needs] / [Owns Rents]

Sensory Assist Equipment: Eyeglasses [Uses Needs] Contacts [Uses Needs] Voice Synthesizer [Uses Needs] Other - Describe [Uses Needs] / [Owns Rents]

Specialty Equipment: Glucometer [Uses Needs] Breast Pump [Uses Needs] Maternity Belt [Uses Needs] Wound Care Supplies [Uses Needs] Infusion Supplies [Uses Needs] Tens Unit [Uses Needs] Nutritional Supplement [Uses Needs] Other - Describe [Uses Needs] / [Owns Rents]

DME provider: [text box]

Comments: [text box]

SPECIAL SERVICES

Have you/has your child received any home or outpatient based therapies / services in the past 12 months?

- Yes
No

Type [text box] If current, list provider here: [text box]

Physical therapy [Home Outpatient] [text box]

Occupational therapy [Home Outpatient] [text box]

Speech therapy [Home Outpatient] [text box]

Skilled nursing [Home Outpatient] [text box]

Home health aide / PCA [Home Outpatient] [text box]

Does your child receive Special Education?

- Yes
No

If yes, is there an IEP in place?

- Yes
No

Do you/your child receive any services from any state or community based agencies?

- Yes
No

If yes, list agency type and service here: [text box]

Do you/does your child use any complimentary sources of care?

- Yes
No

If yes, list sources here: [text box]

Do you have any religious, spiritual or cultural practices that may impact your health status and/or use of health care services?

- Yes
None known

If yes, explain here: [text box]

HOSPITAL and EMERGENCY ROOM USE

Adult: Have you been admitted to a hospital in the last 12 months?

- Yes
No

If yes, number of times: [text box] Reasons: [text box]

Child: Has your child ever been admitted to a hospital?

- Yes
No

Have you/has your child been treated in the emergency room in the last 12 months?

- Yes
No

If yes, number of times: [text box] Reasons: [text box]

PSYCHOSOCIAL ISSUES

Do you have an income?

- No
Yes

If yes, check the source(s):

- SSI
SSDI
EAEDC
Social Security
TAFDC
Workman's Compensation
Retirement
Pension
Other

Have you applied?

- Yes
No

Issues? [text box]

Do you have enough food?

- Yes
No

Do you have any food supplements?

- Food Stamps
WIC
Food Pantry
Meals on wheels / home delivered meals

Have you applied?

- Yes
No

Issues? [text box]

Do you live alone?

- Yes
No

If no, list others in the home: [text box]

Does anyone else in the household have a chronic health condition or disability?

- Yes
No

If yes, explain: [text box]

Do you have any dependent care issues?

- Yes
No

If yes, explain: [text box]

For Child: who provides care during, the day? [text box] the night? [text box]

Is there anyone in your life who can help you with things?

- Yes
No

If yes, who? [text box]

Do you have any housing problems?

- Yes
No

Type of problem: [dropdown menu]

If yes, explain: [text box]

Are there any conditions in your home that put you or your child at risk?

- Yes
No

If yes, explain: [text box]

Have you ever applied for housing / housing subsidy?

- Yes
No

ACTIONS

Do you have any healthcare concerns for your child? [text box]

Would you like to work with a case manager to help you meet your/your child's needs and/or goals for optimal health?

- Yes
No

Would you like to be referred to our Parent Consultant (CSHCN only)?

- Yes
No

RESOURCE COORDINATION

- Completed PT-1/Ride application
Provided numbers for community resources
Completed PCA application
Made community resource referral
Completed Homemaking application
Referral to Case Management
Referral to HFI
Referral to Beacon
Educated member on benefits
Referral to Parent Consultant