health share
Health Share of Oregon

OHSUHealthServices

# Health Assessment

This form asks you questions about your health. Your answers will be kept private. Only people in OHSU Health Services who can help you stay healthy will see this information. Answers to these questions will not change your benefits or insurance. Thank you for helping us get to know you better.

First name: _____

Last name: _____

Birth date: _____

Member ID number: _____

Phone number: _____

Gender: _____

Pronouns: _____

Preferred language: _____

Do you need an interpreter for your health care visits?

☐ Yes ☐ No

Do you need help finding a provider?

☐ Primary care doctor

☐ Specialist doctor

☐ Dentist

☐ Mental health or substance use treatment provider

☐ I do not need help finding a provider

**OHSU Health Services**

3181 SW Sam Jackson Park Road

Portland, OR 97201

Office hours:
Monday to Friday
7:30 a.m. – 5:30 p.m.

If you have questions or need help to fill out this form:

ohsuhscareteam@ohsu.edu

844-827-6572
711 (TTY)

## Transportation to health care appointments

How do you get to your doctor appointments?

☐ I drive my own car
☐ Local transport service
☐ Friend or family member takes me
☐ I take the bus
☐ I don't have transportation
☐ Other (please list) _____

We can help you with a ride to and from medical appointments. Call us toll-free at 503-416-3955. Language interpreter services are available at no cost to you.

## Dental health

Tell us about your teeth. Do you have any of the following?

☐ Mouth pain ☐ Difficulty chewing food
☐ Cavities ☐ None of these

Are you afraid of going to the dentist? ☐ Yes ☐ No

Do you have any urgent dental needs related to the conditions above? ☐ Yes ☐ No

If yes, do you want a care coordinator to reach out to you to help? ☐ Yes ☐ No

## Physical health

Has a doctor or other health professional ever told you that you have any of the physical health conditions below?

☐ Arthritis ☐ Diabetes ☐ Asthma ☐ Heart disease
☐ Cancer ☐ High blood pressure ☐ COPD
☐ Dementia ☐ Stroke ☐ Kidney disease

Other conditions (please list): _____

Do you have any urgent medical needs related to the conditions above? ☐ Yes ☐ No

If yes, do you want a care coordinator to reach out to you to help?
☐ Yes ☐ No

Are you pregnant?

☐ Yes ☐ No ☐ Does not apply to me

If yes, is this a high-risk pregnancy? ☐ Yes ☐No

Compared to last year, how do you rate your physical health?

☐ I feel healthier than I did last year.
☐ I feel a little healthier than last year.
☐ My health feels pretty much the same as last year.
☐ I don't feel as healthy as I did last year.
☐ I feel much less healthy than last year.

## Behavioral health

Has a doctor or other health professional ever told you that you have any of the behavioral health conditions below?

☐ Anxiety ☐ Eating disorder ☐ Gender dysphoria
☐ PTSD ☐ Schizophrenia ☐ Major depressive disorder
☐ Bipolar ☐ Obsessive compulsive disorder

Do you have any urgent needs related to the conditions above? ☐ Yes ☐ No

If yes, do you want a care coordinator to reach out to you to help?
☐ Yes ☐ No

Are you experiencing a behavioral health crisis, such as suicidal thoughts?

☐ Yes – **Please call 988 for fast help** ☐ No

Compared to last year, how do you rate your mental health?

☐ I feel healthier than I did last year.
☐ I feel a little healthier than last year.
☐ My health feels pretty much the same as last year.
☐ I don't feel as healthy as I did last year.
☐ I feel much less healthy than last year.

Do you have any concerns related to substance use, including alcohol? ☐ Yes ☐ No

If yes, do you want a care coordinator to reach out to you to help? ☐ Yes ☐ No

In the last 30 days, have you smoked or used tobacco? ☐ Yes ☐ No

If yes, do you want a care coordinator to reach out to you to help you quit smoking? ☐ Yes ☐ No

## Social health needs

What is your living situation?

☐ I have a steady place to live
☐ I have a place today, but I am worried about losing it
☐ I do not have a steady place to live (I am houseless, temporarily staying with others, or in a motel)

Are you afraid you will not have enough money for any of these items?

(Check all that apply)
☐ Food ☐ Clothing ☐ Housing ☐ Water ☐ Electricity
☐ Transportation ☐ I can purchase everything I need
☐ Other (please list) _____

Do any of the following apply? (Check all that apply)

☐ Concerns for your safety (physical or emotional abuse)
☐ Been involved with foster care
☐ Recent release from jail (within the last 12 months)

## Functional needs

Do you need help every day with any of the following? (Check all that apply)
☐ Bathing ☐ Dressing ☐ Eating or preparing food
☐ Walking ☐ Toileting ☐ Organizing and taking medications

If you checked any of these, do you have people at home who can help you out, like family or friends? ☐ Yes ☐ No

Do you currently have Long Term Service and Supports (LTSS) from Aging and People with Disabilities? ☐ Yes ☐ No

Do you have any intellectual or developmental disabilities? ☐Yes ☐No

If yes, are you working with a Community Developmental Disabilities Program (CDDP)? ☐ Yes ☐ No

**Thank you for filling in this form!**
**Please mail us your answers in the pre-paid return envelope.**