Member Engagement Questionnaire

Date			
Name		**Date of Birth**	
Address			
Home Phone		**Cell Phone**	
Email		**Primary Language**	
Name of Primary Clinic		**Phone number**	
Primary Care Provider			
Emergency Contact		**Phone number**	

Do you have any of the follow health conditions? Check all that apply.

- ☐ Arthritis
- ☐ Cancer
- ☐ Developmental Disabilities
- ☐ Stomach/Bowel Problems
- ☐ High Blood Pressure
- ☐ Traumatic Brain Injury
- ☐ Memory Problems
- ☐ Heart Conditions
- ☐ Diabetes
- ☐ Stroke
- ☐ Pain
- ☐ Asthma/Chronic Obstructive Pulmonary Disease

Other, please list: _____

What health concern causes you the most problems? _____

Do you have any of the following mental health concerns? Check all that apply.

- ☐ Stress
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar
- ☐ Post-Traumatic Stress Syndrome
- ☐ Schizophrenia

Other, please list: _____

Are you currently receiving any of the following services? Check all that apply.

- ☐ Personal Care Assistant
- ☐ Home Delivered Meals
- ☐ Mental Health Services
- ☐ Individual Community Living Support
- ☐ Homemaking
- ☐ Home Health Aid
- ☐ LifeLine
- ☐ Housing Stabilization Services
- ☐ Adult Day Programs
- ☐ Skilled Nurse Visits
- ☐ Case Management
- ☐ Transportation

Other:_____

Would you like to learn more about these programs? ☐ Yes ☐ No

If yes, which programs?_____

Are you having trouble getting your medications?

☐ Yes ☐ No

If yes, please list concern:_____

Pharmacy Name:_____

Have you recently had any of the following changes in your health? Check all that apply.

☐ Hospitalizations: When and for what reason?_____

☐ Emergency room visits: When and for what reason?_____

☐ Falls: How many times in the last year?_____

Are you concerned about falling? ☐ Yes ☐ No

Are you concerned about your balance? ☐ Yes ☐ No

Are you homeless or worried that you might be in the future?

☐ Yes

☐ No

Additional comments:_____

In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have enough money for food?

☐ Yes

☐ No

Additional comments:_____

Do you have trouble finding or paying for a ride (transportation)?

☐ Yes

☐ No

Additional comments:_____

Comments or Questions:

_____

_____

_____

Do you have any goals related to your health?

_____

_____

_____

Would you like a Care Coordinator to contact you regarding your health related goals and needs?

☐ Yes

☐ No

What is the best time of day to reach you?_____

Thank you for your participation!

Please return in the envelope provided.