PLEASE ANSWER ALL QUESTIONS

Contact Information

First name _____ Last name _____
Phone number_____ Date of birth _____
Gold Kidney ID number _____

Type of assessment (*to be completed by case manager*) ☐Initial ☐Annual ☐TOC

Language/Cultural

1. Do you have a language preference other than English?
   ☐Yes ☐No ☐Unable to assess ☐Declined to answer
   If yes, which language?
   ☐Arabic ☐Chinese ☐French ☐German ☐Hindi
   ☐Korean ☐Navajo ☐Spanish ☐Tagalog ☐Vietnamese
   ☐Other _____
2. Are there any specific cultural or religious beliefs that may affect your health care?
   ☐Yes ☐No ☐Unable to assess ☐Declined to answer
   If yes, which of the following?
   ☐Amish ☐Baha'i ☐Buddhism ☐Christianity ☐Hindu
   ☐Jehovah's Witness ☐Judaism ☐Muslim ☐Seventh-day Adventist
   ☐Sikh ☐Other _____
   If any of the above boxes are marked, what are the specifics of those beliefs?
   _____

General

3. In general, how would you rate your current health?
   ☐Excellent ☐Very good ☐Good ☐Fair ☐Poor
   ☐Unable to assess ☐Declined to answer
   Are there specific reasons that made you answer the question the way you did?
   _____

Activity/Exercise

4. How is your current activity level?
   ☐Same as 3 months ago ☐Better than 3 months ago ☐Worse than 3 months ago
   ☐Unable to assess ☐Declined to answer

5. Do you use any of the following assistive devices in your home?
   ☐Cane ☐Walker ☐Crutches ☐Manual Wheelchair ☐Scooter
   ☐Powered Wheelchair ☐None ☐Other _____

Substance Use

6. How often do you use alcohol?
   ☐Never ☐Sometimes ☐Often ☐Very often
   ☐Unable to assess ☐Declined to answer
7. Do you use illegal substances or medications not prescribed to you?
   ☐Yes ☐No ☐Unable to assess ☐Declined to answer
   If yes, do you want to quit using illegal substances or medications not prescribed to you?
   ☐Yes ☐No ☐Unable to assess ☐Declined to answer
8. Do you use tobacco/nicotine products such as e-cigarettes/vape or dip/chew?
   ☐Yes ☐No ☐Unable to assess ☐Declined to answer
   If yes, do you want to quit smoking or using tobacco/nicotine products?
   ☐Yes ☐No ☐Unable to assess ☐Declined to answer

Mental Health

9. Over the past 2 weeks, how often have you had little interest or pleasure in doing things?
   ☐Not at all (0) ☐Several days (1) ☐More than half the days (2)
   ☐Nearly every day (3) ☐Unable to assess ☐Declined to answer
10. Over the past 2 weeks, how often have you been feeling down, depressed, or hopeless?
    ☐Not at all (0) ☐Several days (1) ☐More than half the days (2)
    ☐Nearly every day (3) ☐Unable to assess ☐Declined to answer

Vaccination

11. Have you had a flu shot / vaccine in the last year?
    ☐Yes ☐No ☐Unable to assess ☐Declined to answer
12. Have you had a pneumonia shot / vaccine in the last 5 years? If over age 65.
    ☐Yes ☐No ☐Unable to assess ☐Declined to answer
13. Have you had a shingle shot / vaccine? If over age 50.
    ☐Yes ☐No ☐Unable to assess ☐Declined to answer
14. Have you had a covid shot / vaccine?
    ☐Yes ☐No ☐Unable to assess ☐Declined to answer
    If yes, how many?
    ☐1st dose ☐2nd dose ☐Booster ☐Unable to assess ☐Declined to answer

Chronic Conditions

15. Has a doctor ever told you that you have the following?

☐Diabetes or Prediabetes	☐High Blood Pressure	☐kidney disease
☐Heart disease	☐Asthma	☐COPD
☐HIV/AIDS	☐Stroke	☐Cancer
☐Bipolar disorder	☐Depression	☐Schizophrenia
☐Dementia	☐Hearing problems	☐Vision problems
☐None	☐Other_____	

Current Care

16. Do you have a primary care doctor (regular doctor) that you can easily see on a routine basis?

    ☐Yes ☐No ☐Unable to assess ☐Declined to answer

    If yes, what is the name and contact information of your primary care doctor?

    _____

17. Do you have other doctors/specialists that you see?

    ☐Yes ☐No ☐Unable to assess ☐Declined to answer

    If yes, what is the name and contact information of your specialist as well as what type of doctor are they?

    _____

18. In the past 3 months, have you visited the emergency room and/or stayed overnight in the hospital?

    ☐Yes ☐No ☐Unable to assess ☐Declined to answer

    If yes, how many times and for what reasons?

    _____

19. Do you use any of the following medical devices in your home?

    ☐Oxygen ☐CPAP/BiPAP ☐Wound vac ☐Insulin pump ☐Hospital bed

    ☐None ☐Other _____

Activities of Daily Living (ADLs)

20. Do need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet?

    ☐Yes ☐No ☐Unable to assess ☐Declined to answer

    If yes, do you get the help you need?

    ☐Yes ☐No ☐Unable to assess ☐Declined to answer

Instrumental Activities of Daily Living (IADLs)

21. Do you need help from others to take care of things such as laundry and housekeeping, shopping, using the telephone, food preparation, transportation, or taking your own medications?
    ☐Yes ☐No ☐Unable to assess ☐Declined to answer
    If yes, do you get the help you need?
    ☐Yes ☐No ☐Unable to assess ☐Declined to answer

Fall

22. Have you fallen more than once in the past 6 months? *(A fall is when your body goes to the ground without being pushed.)*
    ☐Yes ☐No ☐Unable to assess ☐Declined to answer

Living Situation

23. What is your living situation today?
    ☐Live in my own home (house, apartment, condo, trailer, etc.).
    ☐Live in a group home
    ☐Live in an assisted living facility
    ☐Live in a nursing home
    ☐Live with relative or friend in their home
    ☐Live in a hotel
    ☐Live in a shelter or homeless
    ☐Other _____
24. Think about the place where you live. Do you have problems with any of the following?
    ☐Pests such as bugs, ants, or mice
    ☐Lack of heat
    ☐Oven or stove not working
    ☐Not able to pay for housing
    ☐Not able to pay for utilities
    ☐Feeling unsafe
    ☐None of the above
    ☐Other _____

Food

25. In the past 12 months, how often have you worried that your food would run out before you had money to buy more?
    ☐Never ☐Sometimes ☐Often ☐Very often

Transportation

26. In the past 12 months, has lack of transportation kept you from medical appointments or from doing things needed for daily living?
    ☐Yes ☐No ☐Unable to assess ☐Declined to answer

Medication

27. Do you have any difficulty getting your medications?
    ☐Yes ☐No ☐Unable to assess ☐Declined to answer
    If yes, what is your difficulty in getting your medications?
    _____
28. Do you understand your medications and how to take them?
    ☐Yes ☐No ☐Unable to assess ☐Declined to answer
    If no, what is that you do not understand?
    _____

Pain

29. In the past 7 days, how much pain have you felt?
    ☐None ☐Some ☐A lot ☐Unable to assess ☐Declined to answer
    If you have been in pain, specify the location or the cause of the pain?
    _____

Advance Directive

30. Do you have an advance directive? *(An advance directive is a written document expressing your medical care wishes should you be unable to speak for yourself.)*
    ☐Yes ☐No ☐Unable to assess ☐Declined to answer
    If no, can we provide you with information regarding advance directives?
    ☐Yes ☐No ☐Unable to assess ☐Declined to answer

Reporting

Assessment Status: ☐Pending ☐Completed ☐Refused
Completion Date: _____
Who completed the form? ☐Member ☐Spouse ☐Family member or Friend