PSYCHOSOCIAL NEEDS ASSESSMENT

Needs Assessment for NEW ADULT patients at Community Health Center of the North Country

☐ N/A if patient is a minor (less than 18 years of age)

If you need help filling out this optional form, please let us know; we are happy to help.
It is our desire to give you the best care possible.
We may have resources that can help with these concerns.

Name____________________________ Date of Birth ______________Date____________
Address____
Phone Number _________________________
Person completing form: _______________________ Relationship:____________________________

Please check yes or no:

1. Do you have trouble getting transportation to appointments?
   Yes No
2. Would you like to hear about insurance programs available to assist with your unmet needs?
   Yes No
3. Are you having trouble finding a safe, permanent place to live?
   Yes No
4. Do you have concerns about your children you would like help with?
   Yes No
5. Would you like information on domestic violence and/or creating a safety plan?
   Yes No
6. Would you like information on alcohol, drug/substance abuse?
   Yes No
7. Would you like information about sexual health and/or pregnancy prevention?
   Yes No
8. Would you like a member of our staff to call you?
   Yes No
   a. If yes, what is the best phone number to call?
      - ☐ The one we have on file
      - ☐ The one at the top of this form
      - ☐ An alternate number:____
9. Is there anything else you feel is important for us to know?________________________________
   ____
   ____

☐ Declined

_______________________________ ______________________
Signature Date

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FOR Community Health Center USE ONLY

CLINIC STAFF

☐ Form Reviewed

Business card & Resource Guide (or equivalent) offered, as appropriate

- Accepted
- Declined
- n/a

Clinic staff signature ________________________________ Date ____________________

CLINIC CASE MANAGER/COUNTY COORDINATOR/DESIGNEE

Action taken: | Notes:

☐ Phone call ______________________

☐ Mailing ______________________

☐ Referral

☐ Other ____

____

☐ None needed at this time

Signature: ____