SSVF Health Care Navigator
Assessment – Detailed

Client Name:	
Date of Birth:	
Client ID:	

Navigator Name:	
Date of Assessment:	

Medical Care Needs

1. In the past 3 months have you experienced any of the following symptoms?

HEAD, EYES, EARS, NOSE, MOUTH, AND THROAT:

- ☐ Blurred vision
- ☐ Ringing in ears
- ☐ Hearing difficulties
- ☐ Mouth sore
- ☐ Loss, change in taste
- ☐ Headache
- ☐ Dizziness
- ☐ Fever

CHEST, LUNG, AND HEART:

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Wheezing (asthma)
- ☐ Persistent cough

GASTROINTESTINAL TRACT:

- ☐ Loss of appetite
- ☐ Nausea
- ☐ Heartburn/acid reflux
- ☐ Indigestion or belching
- ☐ Liver problems
- ☐ Pain or discomfort in the upper abdomen (stomach)
- ☐ Pain or cramps in lower abdomen (colon)
- ☐ Diarrhea-frequent watery bowel movements
- ☐ Constipation
- ☐ Black or tarry stools (not from iron)
- ☐ Vomiting

MUSCULOSKELETAL:

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle pain
- ☐ Weakness of muscles
- ☐ Low back pain
- ☐ Neck pain
- ☐ If you are stiff in the morning, how long does the stiffness last? _____ (hr/min)

NEURO-PSYCHOLOGICAL:

- ☐ Depression
- ☐ Nervousness
- ☐ Trouble thinking or remembering
- ☐ Insomnia
- ☐ Tiredness (Fatigue)

SKIN:

- ☐ Easy bruising
- ☐ Hives or welts
- ☐ Itching
- ☐ Rash

Are you experiencing any other symptoms? _____
_____

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FEMALES ONLY:

Are you currently pregnant? ☐Yes ☐No

If yes, how many times have you been pregnant? _____

Have you ever had a miscarriage? ☐Yes ☐No

Are you experiencing any of the following symptoms?

☐ Pain or swelling in breasts

☐ Pain or discharge from vagina

2. In the past 6 months, have you stayed overnight in the hospital? ☐Yes ☐No
   If yes, for what? _____
3. In the past 6 months, have you had to go to the emergency room ☐Yes ☐No
   If yes, for what? _____
4. In the past 6 months have you been diagnosed with any of the following conditions? (Check box)

☐ High blood pressure	☐ Heart condition
☐ Stroke	☐ Diabetes
☐ Cancer	☐ Lung problems
☐ Ulcers/Stomach problems	☐ Asthma
☐ Liver problems	☐ Thyroid/Endocrine problems
☐ Parkinson's	☐ Mental Illness
☐ Alcohol or drug problem	

   Have you received treatment and/or follow up care for that diagnosis? ☐ Yes ☐ No
5. In the past 6 months have you had an infections other than a cold or the flu?

☐ Sepsis	☐ Urinary Tract Infection
☐ Pneumonia	☐ Kidney Infection
☐ Shingles	☐ Bladder Infection
☐ Bone/Joint infection	☐ Other
☐ Skin infection	

   Have you received treatment and/or follow up care for that infection? ☐ Yes ☐ No
6. Are you currently experiencing any pain? ☐ Yes ☐ No
   If yes, on a scale of 1-10, what is your current pain? _____
   What is the highest your pain has been in the past week? _____
   What is the lowest your pain has been in the past week? _____
7. In the past 6 months, have you had a broken or fractured bone, fractures of the spine or vertebrae, broken back, collapsed vertebrae, or been told you had a "fracture on x-ray"? ☐ Yes ☐ No
   If yes, have you received treatment and/or follow up care for that break? ☐ Yes ☐ No
8. Do need the assistance of a cane, walker, or wheelchair? ☐ Yes ☐ No
9. Do you have a Do Not Resuscitate order in place? ☐ Yes ☐ No

10. How satisfied with your health are you now?
    - ☐ Very satisfied
    - ☐ Satisfied
    - ☐ Neither/neutral
    - ☐ Dissatisfied
    - ☐ Very dissatisfied

11. In the past 6 months have you limited your usual activities because of your health? ☐ Yes ☐ No

Prescriptions

1. Ask the patient to display containers for all prescription medications, OTC products and herbal and nutritional products being taken (this can be done with photos). If not available, ask the patient to supply any medication lists that providers have given to the patient. If not available, ask the patient to recall the medications. In all cases, the patient should be prompted about patches, creams, eye drops, inhalers, sample medications, shots, optics, herbals, vitamins, minerals, and food supplements. Ask the patient to document all medications being taken, their description, dose, route, and directions for taking.

Medication	**Dose**	**Prescribing Physician**	**Date of Prescription**

2. Are you taking all your medications as prescribed? ☐ Yes ☐ No
3. Does anyone normally help you with taking your medicine? ☐ Yes ☐ No
4. How many times in the past 2 weeks have you forgotten a dose of a medication, or think you may have taken a medication more times than prescribed? ☐ Yes ☐ No
5. Have you ever not filled a prescription due to cost? ☐ Yes ☐ No
6. Have you ever had or do you now have any side effects from taking any medications? ☐ Yes ☐ No
   If yes, which drug and what happened? _____
   a. Did you stop taking the drug? ☐ Yes ☐ No
   b. Reduce the amount of the drug you are taking? ☐ Yes ☒ No
   c. Contact your doctor? ☐ Yes ☐ No

7. Do you have any conditions for which you are NOT taking any prescription or non-prescription medications or other types of curative products, but which you believe medication may be helpful?
   _____
8. Do you have any questions or concerns about your medications? _____
_____

Preventive care needed

1. In the past 12 months, have you had any of the following? (Check box)
   - ☐ Cholesterol screening
   - ☐ Blood pressure screening
   - ☐ Diabetes screening
   - ☐ Flu shot
   - ☐ Pneumonia shot
   - ☐ Other vaccinations
   - ☐ Mammogram
   - ☐ Pap smear
   - ☐ Prostate exam
   - ☐ Colonoscopy
   - ☐ Skin cancer screening

Oral health

1. Have you been seen by a dentist in the past year? ☐ Yes ☐ No
2. How often do you brush your teeth? _____
3. Are you currently experiencing any pain in your mouth, teeth or gums? ☐ Yes ☐ No
   If yes, what are you experiencing? _____
4. Do you wish your teeth looked different? ☐ Yes ☐ No

Vision care

1. Have you had your eyes checked in the past year? ☐ Yes ☐ No
2. Has anyone ever told you that you should wear glasses? ☐ Yes ☐ No
3. Do you regularly wear glasses? ☐ Yes ☐ No
4. Are you currently experiencing any problems with your eyes? ☐ Yes ☐ No
   If yes, what are those problems? _____
5. How often do you experience:
   a. Blurred vision: ☐ Never ☐ Sometimes ☐ Often
   b. Double vision: ☐ Never ☐ Sometimes ☐ Often
   c. Headaches: ☐ Never ☐ Sometimes ☐Often
   d. Burning, itchy, watery eyes: ☐ Never ☐ Sometimes ☐Often
   e. Eye strain: ☐ Never ☐ Sometimes ☐Often
   f. Difficulty seeing things far away: ☐ Never ☐ Sometimes ☐Often
   g. Difficulty seeing things up close: ☐ Never ☐ Sometimes ☐Often

Hearing

1. Have you had your hearing checked in the past year? ☐ Yes ☐ No
2. Have you ever been told you had hearing loss or needed to wear hearing aids? ☐ Yes ☐ No

3. Are you currently experiencing any issues with your ears? ☐ Yes ☐ No
   If yes, what are those problems? _____
4. How often do you:
   a. Have to ask people to repeat themselves: ☐ Never ☐ Sometimes ☐Often
   b. Have a hard time understanding what people are saying: ☐ Never ☐ Sometimes ☐Often
   c. Have a difficult time hearing people in crowded spaces: ☐ Never ☐ Sometimes ☐Often
   d. Have a hard time hearing people on the telephone: ☐ Never ☐ Sometimes ☐Often
   e. Hear ringing in your ears: ☐ Never ☐ Sometimes ☐Often
   f. Not hear something that someone else hears: ☐ Never ☐ Sometimes ☐Often
   g. Have people complain that your TV/music is too loud: ☐ Never ☐ Sometimes ☐Often

Mental health

1. Over the past 2 weeks, how often have you been bothered by any of the following problems?
   a. Little interest or pleasure in doing things: ☐ Never ☐ Sometimes ☐Often
   b. Feeling down, depressed, or hopeless: ☐ Never ☐ Sometimes ☐Often
2. How often do you feel lonely or isolated from those around you? ☐ Never ☐ Sometimes ☐Often
3. Stress means a situation in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his or her mind is troubled all the time. How often do you feel this kind of stress these days? ☐ Never ☐ Sometimes ☐Often

Suicide risk

1. Have you ever thought of killing yourself? ☐ Never ☐ Sometimes ☐Often
2. If anything other than Never, when was the last time you thought of killing yourself?
   _____
3. Have you ever previously attempted suicide? ☐ Yes, once ☐ Yes, more than once ☐ No
4. Do you have a plan for how you would kill yourself? ☐ Yes ☐ No
5. Describe: _____
6. Do you have access to the things you need to carry out your plan? ☐ Yes ☐ No

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Substance use

1. Have you used any of the following substances?

*If haven't used any substance EVER, skip to section 7

Substance	*Have you ever used this?*	*If ever used it, ask: in the past 3 months?*	*For use in the past 3 months, ask: How often do you use*	*For use in past 3 months, ask: How have you taken this? Check all that apply*
Tobacco	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	____ cigarettes smoked weekly (for other forms of tobacco, # times used weekly) ☐ < weekly ☐ Declined (reminder: 1 pack = 20 cigarettes)	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Alcohol	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	___ drinks weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Marijuana	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	___ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
PCP/Hallucinogens	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	___ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Crystal Meth	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	____ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected

				☐ Declined (no answer)
Cocaine/Crack	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	___ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Heroin	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	___ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Opioids	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	___ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Rx Pills to get high	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	___ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Hormones/Steroids	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	___ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted ☐ Injected ☐ Declined (no answer)
Anything Else _____	☐ Yes ☐ No ☐ Declined	☐ Yes ☐ No ☐ Declined	___ times weekly or ☐ < weekly ☐ Declined	☐ Orally (eaten/swallowed) ☐ Smoked ☐ Inhaled/snorted

				☐ Injected ☐ Declined (no answer)

2. Do you participate in a daily opioid replacement treatment program such as methadone or suboxone? ☐ Yes ☐ No ☐ Declined

Only ask these questions if there was any indication that the Veteran injects drugs:

3. Do you currently receive clean syringes from a syringe exchange program or pharmacy? ☐ Yes ☐ No ☐ Declined
4. Have you ever shared needles or injection equipment with others? ☐ Yes ☐ No ☐ Declined
   If yes, when was the last time you shared needles or injection equipment?
   ☐ In the past 3 months
   ☐ Between 3 and 12 months ago
   ☐ More than 12 months ago
   ☐ Declined

Safety - Because violence and abuse happens to a lot of people and affects their health we are asking the following questions:

1. How often does anyone, including family and friends, physically hurt you? ☐ Never ☐ Sometimes ☐ Often
2. How often does anyone, including family and friends, insult or talk down to you? ☐ Never ☐ Sometimes ☐ Often
3. How often does anyone, including family and friends, threaten you with harm? ☐ Never ☐ Sometimes ☐ Often
4. How often does anyone, including family and friends, scream or curse at you? ☐ Never ☐ Sometimes ☐ Often

Activities of Daily Living

1. Do you need support with any of the following activities?
   a. Bathing: ☐ Never ☐ Sometimes ☐ Often
   b. Dressing: ☐ Never ☐ Sometimes ☐ Often
   c. Feeding: ☐ Never ☐ Sometimes ☐ Often
   d. Toileting: ☐ Never ☐ Sometimes ☐ Often
   e. Continence: ☐ Never ☐ Sometimes ☐ Often
   f. Transferring: ☐ Never ☐ Sometimes ☐ Often
   g. Administering medication: ☐ Never ☐ Sometimes ☐ Often
   h. Grocery shopping: ☐ Never ☐ Sometimes ☐ Often
   i. Preparing meals: ☐ Never ☐ Sometimes ☐ Often
   j. Housekeeping: ☐ Never ☐ Sometimes ☐ Often
   k. Managing finances: ☐ Never ☐ Sometimes ☐ Often
   l. Driving and transportation: ☐ Never ☐ Sometimes ☐ Often

m. Using the phone: ☐ Never ☐ Sometimes ☐ Often

2. If for any reason you need help with any of these day-to-day activities, do you get the help you need? ☐ Yes ☐ Sometimes ☐ No

Barriers to Care

1. Communication
    a. Do you have access to a cell phone or other means to make medical appointments? ☐ Yes ☐ No
    b. Do you have a confidential way that providers can leave you messages? ☐ Yes ☐ No
    c. Do you have access to a tablet or computer to participate in virtual appointments? ☐ Yes ☐ No
    d. Do you have access to wifi for the tablet or computer to participate in virtual appointments? ☐ Yes ☐ No
2. Transportation
    a. In the past 3 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? ☐ Yes ☐ No
    b. Do you have a bus pass or other means of paying for public transportation? ☐ Yes ☐ No
3. Childcare (ask only if there are children in the home)
    a. In the past 3 months, has lack of childcare kept you from medical appointments, meetings, work or from getting things needed for daily living? ☐ Yes ☐ No

Social Supports

1. Do you have regular contact with your family? ☐ Yes ☐ No
2. Do you consider your family a source of support for your medical needs? ☐ Yes ☐ No
3. Do you have close friends that you have regular contact with? ☐ Yes ☐ No
4. Have you given anyone a Medical Power of Attorney? ☐ Yes ☐ No
   If yes, who: _____
5. Do you consider your friends a source of support for your medical needs? ☐ Yes ☐ No
6. Do you regularly work with a case-manager other than your SSVF case-manager? ☐ Yes ☐ No
7. Do you think it would be helpful for me to talk with any of these people on your behalf about your health in the past or the work we will be doing together to access health care? ☐ Yes ☐ No (If yes, completed appropriate ROI)

Health literacy

1. Do you have difficulty concentrating, remembering, or making decisions?
   ☐ Yes ☐ No ☐ Sometimes
2. Do you ever need help reading hospital materials?
   ☐ Yes ☐ No ☐ Sometimes
3. Would you prefer to have someone help you when you read instructions, pamphlets, or other written materials?
   ☐ Yes ☐ No

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4. Do you have all the information you need to make decisions about your health? ☐ Yes ☐ No
5. Do you need more education on any of your diagnoses or conditions? ☐ Yes ☐ No
6. Do you feel confident that you can tell a doctor concerns you have even when they don't ask? ☐ Yes ☐ No

_____	_____	_____	_____
Client Signature	**Date**	**Staff Signature**	**Date**