Initial Encounter Assessment

CLIENT INFORMATION

YOUR INFORMATION

First Name:_____Last Name _____

Address:_____City:_____State:_____Zip:_____

Home Phone: (____)_____-__Cell Phone: (_____)_____-_____

Email address: _____

Date of Birth:_____/___/_____ Gender: ❑ Male ❑ Female Hispanic: ❑ Yes ❑ No

Race (check all that apply): ❑White ❑Black ❑Mexican ❑Asian ❑Native American ❑Pacific Islander ❑Other_____

Are you limited in any way in any activities because of physical, mental or emotional problems?
❑Yes ❑No ❑Don't Know ❑Don't want to answer

Do you now have any health problem that requires you to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone?
❑Yes ❑No ❑Don't Know ❑Don't want to answer
If yes, what type of disability?
_____

Are you a Refugee? ❑Yes ❑No ❑Unknown
If yes, where from? _____

County of Residence in Nebraska: _____
Preferred Counties in Nebraska: _____

Do you have a primary care physician? ❑Yes ❑No

Do you have Health Insurance?
❑Employer Coverage ❑Health Market ❑Medicare ❑Medicaid ❑No

Do you smoke, Includes cigarettes, pipes, or cigars (smoked tobacco in any form)? ❑Current Smoker ❑Quit (1-12 months ago) ❑Quit (More than 12 months ago) ❑Never Smoked

Has your doctor, nurse, or other health professional EVER told you that you have high blood pressure?
❑Yes ❑No ❑NA

Do you take any medication prescribed by your doctors NOW to lower high blood pressure?
❑Yes ❑No ❑Don't Know ❑NA

During the past 7 days, how many days (including today) did you take your blood pressure medicine?
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑DK

Has your doctor, nurse or other health professional EVER told you that you have diabetes?
❑Yes ❑No ❑NA

Do you take any medication prescribed by your doctors NOW to lower diabetes (blood sugar)?
❑Yes ❑No ❑Don't Know ❑NA

During the past 7 days, how many days (including today) did you take your diabetes medicine?
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑DK

Has your doctor, nurse or other health professional EVER told you that you have high cholesterol?
❑Yes ❑No ❑NA

Do you take any medication prescribed by your doctors NOW to lower high cholesterol?
❑Yes ❑No ❑Don't Know ❑NA

During the past 7 days, how many days (including today) did you take your cholesterol medicine?
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑DK

Have you been diagnosed by a healthcare provider as having Coronary Heart Disease/Chest Pain?
❑Yes ❑No ❑Don't Know

Have you been diagnosed by a healthcare provider as having Congenital Heart Defects?
❑Yes ❑No ❑Don't Know

Have you been diagnosed by a healthcare provider as having Heart Failure?
❑Yes ❑No ❑Don't Know

Have you been diagnosed by a healthcare provider as having Stroke/Transient Ischemic Attack (TIA)?
❑Yes ❑No ❑Don't Know

Have you been diagnosed by a healthcare provider as having Vascular Disease?
❑Yes ❑No ❑Don't Know

Have you been diagnosed by a healthcare provider as having a Heart Attack?
❑Yes ❑No ❑Don't Know

Are you taking aspirin daily to help prevent a Heart Attack or Stroke?
❑Yes ❑No ❑Don't Know

Have you had a mammogram in the last 2 years?
❑Yes ❑No ❑Don't Know

Have you had a pap test in the last 3 years?
❑Yes ❑No ❑Don't Know

Have you been screened for colorectal cancer?
❑Yes ❑No ❑Don't Know