

**Jefferson Internal Medicine 1817 Grant Patient Intake Form**

**Diagnosis Knowledge**

- 1. In general, how would you rate your health?
  - Very good (0)
  - Good (1)
  - Fair (2)
  - Poor (3)
- 2. Do you use a blood pressure cuff to monitor your blood pressure at home?
  - Yes
  - No

If yes, how often do you monitor your blood pressure?

  - Every day
  - Several times per week
  - Not at all
- 3. Have you ever been told by your doctor or another health care provider that you have high blood pressure?
  - Yes
  - No
- 4. Do you have concerns about your blood pressure?
  - Yes
  - No
- 5. What, if anything, do you need to help better manage your blood pressure? Examples could be things like a BP monitor, social support, and reminders to check your BP, access to fresh food and meals, etc.

Answer:

**Medication Adherence**

**According to your medical records, you have been prescribed medications. Many people have a difficult time taking medicines. I have some questions about your medicines.**

- 1. How often do you forget to take your medicine?

1	2	3	4
None of the time	Some of the time	Most of the time	All of the time

- 2. How often do you decide to not take your medicine?

1	2	3	4
None of the time	Some of the time	Most of the time	All of the time

- 3. How often do you forget to get your medicine filled?

1	2	3	4
None of the time	Some of the time	Most of the time	All of the time

- 4. How often do you run out of your medicine?

1	2	3	4
None of the time	Some of the time	Most of the time	All of the time

- 5. How often do you miss taking your medicine because you feel better?

1	2	3	4
None of the time	Some of the time	Most of the time	All of the time

6. How often do you miss taking your medicine when you feel sick?

1	2	3	4
None of the time	Some of the time	Most of the time	All of the time

7. How often do you plan ahead and refill your medicines before they run out?

1	2	3	4
None of the time	Some of the time	Most of the time	All of the time

**Total Score:** \_\_\_\_\_ (out of total score of 28)

**Medication Adherence Scoring**

>7	Referral to Pharmacy
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**Social Determinants of Health**

1. What is your living situation today?

- I have a steady place to live
- I have a place to live today, but **I am worried** about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

2. Think about the place you live. Do you have problems with any of the following?<sup>4</sup>

CHOOSE ALL THAT APPLY

- Pests such as bugs, ants, or mice
- Mold
- Lead paint or pipes
- Lack of heat
- Oven or stove not working
- Smoke detectors missing or not working
- Water leaks
- None of the above

Some people have made the following statements about their food situation. Please answer whether the statements were OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months.<sup>5</sup>

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Often true
- Sometimes true
- Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- Often true
- Sometimes true
- Never true

**Transportation**

1. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?<sup>6</sup>

- Yes
- No

## Utilities

1. In the past 12 months has the electric, gas, oil, or Water Company threatened to shut off services in your home?  
 Yes  
 No  
 Already shut off
2. How hard is it for you to pay for the very basics like food, housing, medical care, and heating? Would you say it is:  
 Very hard  
 Somewhat hard  
 Not hard at all
5. If for any reason you need help with day-to-day activities such as bathing, preparing meals, shopping, managing finances, etc., do you get the help you need?  
 I don't need any help  
 I get all the help I need  
 I could use a little more help  
 I need a lot more help
6. How often do you feel lonely or isolated from those around you?  
 Never  
 Rarely  
 Sometimes  
 Often  
 Always
7. In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?  
 0  
 1  
 2  
 3  
 4  
 5  
 6  
 7
8. On average, how many minutes did you usually spend exercising at this level on one of those days?  
 0  
 10  
 20  
 30  
 40  
 50  
 60  
 90  
 120  
 150 or greater

Follow these 2 steps to decide if the person has a physical activity need:

1. Calculate ["number of days" selected] x ["number of minutes" selected] = [number of minutes of exercise per week]
2. Apply the right age threshold:
  - Under 6 years old: You can't find the physical activity need for people under 6.
  - Age 6 to 17: Less than an average of 60 minutes a day shows an HRSN.
  - Age 18 or older: Less than 150 minutes a week shows an HRSN.

## Disabilities

1. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)
  - Yes
  - No
2. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (15 years old or older)
  - Yes
  - No

## Mental Health

- a.** Little interest or pleasure in doing things?
  - Not at all (0)
  - Several days (1)
  - More than half the days (2)
  - Nearly every day (3)
- b.** Feeling down, depressed, or hopeless?
  - Not at all (0)
  - Several days (1)
  - More than half the days (2)
  - Nearly every day (3)

## Stress

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. Do you feel this kind of stress these days?
  - Not at all
  - A little bit
  - Somewhat
  - Quite a bit
  - Very much