



Today's Date: _____

Your Name: (please print) _____

Your MO HealthNet (Medicaid) ID#: _____

Your Date of Birth: (month, day, year) _____

Phone Number Where We Can Reach You: _____ (area code) _____ - _____

Your Doctor / Clinic Name (if you have one): _____

Your Doctor / Clinic Phone #: _____

<u>MO HealthNet Health and Wellness Program Assessment</u>	
May we have permission to contact your doctor as needed? (circle one)	Yes / No
Primary Language	English / Other (if Other, please list here: _____)
What is the highest grade you finished in school?	_____
How many times have you stayed over night in the hospital in the past year?	_____
Why were you in the hospital?	
How many times have you been in the Emergency Room in the past year?	_____
Why did you go to the Emergency Room?	
Have you seen your family doctor or healthcare provider in the past 3 months?	Yes / No
Did you receive a flu shot in the past year?	Yes / No

Assessment continued on the back of this page

Have you received a vaccine to prevent pneumonia in the past 5 years?	Yes / No
Are you able to manage your own physical activities, e.g. bathe, dress, clean? (circle 1 for very difficult, 10 for very easily)	1 2 3 4 5 6 7 8 9 10 Difficult Easy
Do you smoke or use chewing tobacco?	Yes / No
Do you smoke cigarettes?	Yes / No
Do you smoke cigars?	Yes / No
Do you smoke a pipe?	Yes / No
Have you had your blood pressure checked in the past 6 months?	Yes / No
Systolic blood pressure (top number)	_____
Diastolic blood pressure (bottom number)	_____
How tall are you?	_____ Feet _____ Inches
How much do you weigh?	_____ Pounds
Do you take your medications as prescribed by your doctor?	Yes / No
Circle any conditions you may have:	Diabetes High Cholesterol Low Back Pain Sickle Cell Heart Disease Heart Failure
List any other conditions you may have here:	

