HEALTH CARE FOR THE HOMELESS, INC.
INTERDISCIPLINARY ASSESSMENT FORM

DATE: _____

CONFIDENTIALITY FORM SIGNED? ☐ YES ☐ NO

PRESENTING PROBLEM: _____

WHERE STAYED LAST NIGHT: ☐ STREET ☐ DOUBLING UP ☐ HOUSED ☐ SHELTER ☐ TRANSITIONAL HOUSING ☐ OTHER _____

INCOME? ☐ NO ☐ YES

BENEFITS? ☐ NO ☐ YES (CHECK ALL THAT APPLY)

☐ FOOD STAMPS ☐ TEMHA ☐ BUS PASS
☐ PA ☐ MPC (PCMI) ☐ MA
☐ VA ☐ SSI/SSDI ☐ OTHER _____

SOCIAL SUPPORT:

FAMILY IN AREA? ☐ NO ☐ YES _____ CONTACT WITH FAMILY? ☐ NO ☐ YES _____

FRIENDS IN AREA? ☐ NO ☐ YES _____ CONTACT WITH FRIENDS ☐ NO ☐ YES _____

WHAT IS YOUR RELIGIOUS AFFILIATION/PRACTICE? _____

ARE THERE ANY CULTURAL/RELIGIOUS BELIEFS OR PRACTICES THAT YOU WANT US TO BE AWARE OF? ☐ NO ☐ YES _____

MEDICAL HISTORY:

HISTORY OBTAINED FROM: ☐ PATIENT ☐ OTHER: _____

MEDICATIONS: _____

DRUG ALLERGIES: ☐ NO ☐ YES _____

	COMMENTS
☐ NO HEALTH PROBLEMS IDENTIFIED	
☐ HIV DISEASE	
☐ SEIZURES	
☐ STROKES	
☐ ASTHMA	
☐ HIGH BLOOD PRESSURE	
☐ HEART ATTACK	

	COMMENTS
☐ HEPATITIS	
☐ DIABETES	
☐ KIDNEY PROBLEMS	
☐ STOMACH PROBLEMS	
☐ CANCER	
☐ OTHER:	

NUTRITIONAL ASSESSMENT:

WHERE DO YOU EAT? ☐ SOUP KITCHEN ☐ OTHER (DESCRIBE): _____

WHAT DID YOU EAT FOR:	BREAKFAST	LUNCH	DINNER	SNACK

IS THIS TYPICAL? ☐ NO ☐ YES

CLIENT LAST NAME: _____ FIRST: _____ HCH#: _____

SPECIAL DIETARY NEEDS: _____

UNEXPLAINED WEIGHT CHANGE: ☐ NO ☐ YES/ IF YES, HOW MUCH OVER WHAT PERIOD OF TIME? _____

FUNCTIONAL STATUS:

INDEPENDENT WITH ACTMTIES OF DAILY LIVING? ☐ NO ☐ YES

WALKS INDEPENDENTLY? ☐ YES ☐ NO ☐ ASSISTIVE DEVICES: ☐ WALKER ☐ WHEELCHAIR ☐ CANE ☐ PROSTHESIS ☐ CRUTCHES ☐ OTHER: _____

SPEAKS ENGLISH? ☐ YES ☐ NO IF NO, PRIMARY LANGUAGE: _____

☐ VISUAL IMPAIRMENT: ☐ GLASSES ☐ BLIND ☐ OTHER: _____

☐ HEARING IMPAIRMENT: HEARING AID: ☐ RIGHT ☐ LEFT ☐ DEAF • 1 SIGN ☐ LIP READS INTERPRETER: _____

COMMENTS: _____

☐ MEMORY/COGNITIVE PROBLEMS: ☐ CHRONIC ☐ ACUTE

DESCRIBE: _____

☐ COMMUNICATION PROBLEMS: _____

MENTAL HEALTH ASSESSMENT:

1. HAVE YOU EMR HAD OUTPATIENT MENTAL HEALTH SERVICES? ☐ NO ☐ YES _____

2. HAVE YOU EVER SPENT A NIGHT OR MORE ON AN INPATIENT PSYCHIATRIC UNIT? ☐ NO ☐ YES _____

3. HAVE YOU EVER BEEN ON A MEDICATION FOR BAD NERVES, ANXIETY OR DEPRESSION? ☐ NO ☐ YES _____

4. HAVE YOU EVER THOUGHT ABOUT HURTING YOURSELF OR OTHERS? ☐ NO ☐ YES _____

5. HAVE YOU EVER TRIED TO HURT YOURSELF OR SOMEONE ELSE? ☐ NO ☐ YES _____

6. HAS ANYONE EVER TOUCHED YOU IN A WAY THAT WAS FRIGHTENING, PAINFUL OR MADE YOU FEEL UNCOMFORTABLE? ☐ NO ☐]YES _____

7. WHAT HAPPENS WHEN YOU ARGUE WITH OTHERS? _____

SUBSTANCE ABUSE ASSESSMENT: *[IF YES TO ANY QUESTION, NOTE LAST DRUG/ETOH USE AND SKIP TO NEXT SECTION]*

1. HAVE YOU EVER BEEN IN A SUBSTANCE ABUSE PROGRAM BEFORE OR ARE YOU IN ONE NOW ? ☐ NO ☐ YES _____

2. HAVE YOU FELT YOU OUGHT TO CUT DOWN ON YOUR DRINKING OR DRUG USE ? • J NO ☐ YES _____

SUBSTANCE ABUSE ASSESSMENT *(CONT'D.)*:

3. HAVE PEOPLE ANNOYED YOU BY CRITIZING YOUR DRINKING OR DRUG USE? ☐ No ☐ YES _____

4. HAVE YOU FELT BAD OR GUILTY ABOUT YOUR DRINKING OR DRUG USE? ☐ No ☐ YES _____

5. HAVE YOU EVER HAD A DRINK OR USED DRUGS FIRST THING IN THE MORNING TO STEADY YOUR NERVES, GET RID OF A HANGOVER OR TO GET THE DAY STARTED? ☐ No ☐ YES _____

ADVANCE DIRECTIVE:

DOES CLIENT HAVE ADVANCE DIRECTIVE? ☐ YES / IF YES, COPY REQUESTED FROM PT./FAMILY

☐ No, INFORMATION MATERIAL GIVEN? ☐ YES ☐ No

EDUCATION:

IS THERE ANYTHING YOU WOULD LIKE INFORMATION ABOUT TODAY? ☐ No ☐ YES

FOR EXAMPLE: ☐ MEDICATIONS ☐ SHELTER ☐ FOOD ☐ BENEFIT INFORMATION

☐ OTHER _____

EDUCATIONAL MATERIALS GIVEN TO CLIENTS? ☐ No ☐ YES _____
(DOCUMENT/MATERIALS GIVEN)

REFERRAL MADE TO:

	ACCEPT	DECLINE	COMMENTS
☐ ADDICTIONS			
☐ SOCIAL SERVICES			
☐ MEDICAL			
☐ MENTAL HEALTH			

SIGNATURE: _____ DATE: _____