TheHealthPlan
1110 Main Street
Wheeling, WV 26003-2704

– Adult –
Health Screener

Enclosed is a health screener and pre-paid envelope. At your earliest convenience please complete the screener so that we may better understand your health care needs. Once you've completed the screener you can mail it back to us in the envelope provided.

Once we review the screener, a health navigator may call you to follow up on your health conditions and discuss any assistance we may be able to provide.

If you have any questions please feel free to contact an Outreach Representative at 1.855.577.7124 (TTY: 711).

Our hours of operation are 8:00 am to 5:00 pm, EST, Monday – Friday.

Assessment Date: _____ Date of Birth: _____ (mm/dd/yyyy)

Your Full Name? _____

HID: _____ Medicaid ID: _____

Gender at birth: ☐ Male ☐ Female ☐ I prefer not to say

Which of the following most accurately describes you now?
☐ Male ☐ Female Non-binary ☐ Transgender ☐ Intersex ☐ Other ☐ I prefer not to say

Race/Ethnicity:

☐ American Indian and Alaska Native, non-Hispanic
☐ Asian, non-Hispanic
☐ Black or African American, non-Hispanic
☐ Hispanic
☐ Native Hawaiian and Other Pacific Islander, non-Hispanic
☐ White, non-Hispanic
☐ Multiracial non-Hispanic
☐ Other race, non-Hispanic

Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Email: _____ My preferred method of contact is: _____

What language do you speak at home? ☐ English ☐ Spanish ☐ Other: _____

Your primary care doctor: _____ Last seen: _____

Your dentist: _____ Last seen: _____

Your eye doctor: _____ Last seen: _____

Do you feel like you have problems getting care? ☐ Yes ☐ No

Explain: _____

Are you up to date on immunizations? ☐ Yes ☐ No ☐ I don't know

How would you rate your general physical health? ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

How would you rate your general mental health? ☐ Excellent ☐ Very Good ☐ Fair ☐ Poor

Are you pregnant? ☐ Yes, due date: _____ ☐ No ☐ Not applicable

Have you been hospitalized (medical or mental hospital) in the last 6 months? ☐ Yes ☐ No

If yes, explain: _____

How many times have you been treated in the emergency department in the last 6 months?
☐ None ☐ Once or Twice ☐ Three Times or More

Do you take medicine? ☐ Yes ☐ No Do you understand your medicine(s)? ☐ Yes ☐ No

Do you need an urgent refill for a medical or mental health medication? ☐ Yes ☐ No

Explain: _____

Do you receive any of these services?

☐ Speech Therapy
☐ Physical Therapy
☐ Occupational Therapy
☐ Respiratory Therapy
☐ Nursing Services
☐ Home Health Aide
☐ Socially Necessary Services
☐ Waiver Services
☐ SSI/SSDI

Do you use medical equipment?

☐ Wheelchair ☐ Oxygen ☐ Special bed ☐ Insulin pump ☐ Prosthetics/orthotics (artificial limbs/braces)
☐ Ventilator/CPAP/BiPAP ☐ Hearing aid/cochlear implant ☐ Feeding pump/tube feeding supplies

Walking Status? ☐ Walk unassisted ☐ Use a cane or walker ☐ Use a wheelchair or scooter ☐ Bed bound

Have you fallen in the last 12 months? ☐ Yes ☐ No

Do you have a hearing problem or do others think you have a hearing problem? ☐ Yes ☐ No

Do you have difficulty driving, watching TV, reading, or doing your daily activities because of your eyesight? ☐ Yes ☐ No

Does lack of money ever make it hard for you to pay home related bills like water or heating? ☐ Yes ☐ No

Does lack of money ever make it hard to pay for medical, behavioral or dental expenses? ☐ Yes ☐ No

Do you ever go hungry because there is not enough food in the home? ☐ Yes ☐ No

Do you have stable housing/a safe home environment? ☐ Yes ☐ No

Explain: _____

Do you have a dependable way to get to appointments and the store? ☐ Yes ☐ No

Have you had or do you currently have mental, physical or sexual abuse or have you been exposed to extreme violent behavior in your past? ☐ Yes ☐ No

Do you need counseling? ☐ Yes ☐ No Explain: _____

Are you employed? ☐ Yes ☐ No

Do you want help with life skills like getting child care, parenting classes, money management, obtaining personal documents like birth certificates/social security cards, or help with job training? ☐ Yes ☐ No

Do you smoke/use tobacco? ☐ Yes ☐ No Do you want help quitting smoking/tobacco? ☐ Yes ☐ No

Do you have a problem with drugs or alcohol or do others think you have a problem with drugs or alcohol? ☐ Yes ☐ No

Over the past two weeks, how often have you been bothered by the following problems:

Little interest or pleasure in doing things
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed or hopeless
☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

What is your normal pain level on a scale of 0 (no pain) to 10 (unbearable pain)?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Because of a health or physical problem, do you have any difficulty doing the following activities without special equipment or help from another person?

	I do not have difficulty	Yes, I have difficulty	I am not able to do this activity unassisted
Bathing	☐	☐	☐
Dressing and grooming	☐	☐	☐
Eating	☐	☐	☐
Using the toilet	☐	☐	☐
Getting in and out of bed or chairs	☐	☐	☐
Managing medications	☐	☐	☐
Managing money	☐	☐	☐
Household activities like food prep, laundry & housekeeping	☐	☐	☐
Shopping for groceries and clothes	☐	☐	☐
Getting places out of walking distance	☐	☐	☐

Do you have a Medical Power of Attorney?
(Someone to make medical decisions for you in the event you are unable to).

☐ Yes ☐ No, but I would like more information about medical power of attorney
☐ No, and I do not wish to receive information about medical power of attorney

Do you have a living will/advance directive?
(Documents that make your health care wishes known if you are unable to voice them)

☐ Yes ☐ No, but I would like more information about living will/advance directives
☐ No, and I do not wish to receive information about living will/advance directives

Please choose the answer that best describes your current status and related needs for each condition below:

I have breathing problems, like COPD (chronic obstructive pulmonary disease) or asthma.
☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help.
☐ Yes, and I would like a nurse to help me better manage this condition.
☐ No, I do not have this condition

I have heart failure (CHF-congestive heart failure) or an enlarged heart.
☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help.
☐ Yes, and I would like a nurse to help me better manage this condition.
☐ No, I do not have this condition

I have diabetes (blood sugar problems).
☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help.
☐ Yes, and I would like a nurse to help me better manage this condition.
☐ No, I do not have this condition

I have chronic kidney disease.
☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help.
☐ Yes, and I would like a nurse to help me better manage this condition.
☐ No, I do not have this condition

I am obese (with or without a diagnosis of pre-diabetes)
☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help.
☐ Yes, and I would like a nurse to help me better manage this condition.
☐ No, I do not have this condition

I have a behavioral health condition like depression, anxiety, bipolar disorder, or schizophrenia.
☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help.
☐ Yes, and I would like a nurse to help me better manage this condition.
☐ No, I do not have this condition

I am in active treatment for cancer.
☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help.
☐ Yes, and I would like a nurse to help me better manage this condition.
☐ No, I do not have this condition

I have organ failure (in evaluation for transplant, listed for transplant or transplanted within the last year).
☐ Yes, but this condition is well managed by my doctor/I do not feel like I need more help.
☐ Yes, and I would like a nurse to help me better manage this condition.
☐ No, I do not have this condition

I would like for a nurse from The Health Plan to contact me for help with something not identified on this screening. ☐ Yes ☐ No