McLaren MEDICAL GROUP

Needs Assessment

Patient Name (First, Last) _____ **Date of Birth** _____

Date of Assessment: _____

Patient: Please fill out the information below to better assist us with your care.

Our goal is to educate our patients in order to provide the best possible care. Would you consider yourself ready to learn? ☐ Yes ☐ No

Learning Preference	**Cultural Considerations**
Check all that apply.	Do you have any religious or cultural practices that we should be aware of?
☐ Demonstration	☐ Yes ☐ No If Yes, please describe: _____
☐ Video	**Communication Needs**
☐ Read Instructions	Do you have impaired vision or are blind? ☐ Yes ☐ No
☐ Picture Instructions	Can you read? ☐ Yes ☐ No
☐ No preference	Can you write? ☐ Yes ☐ No

Language Preference

☐ English ☐ Other, please list _____

Do you need an interpreter? ☐ Yes ☐ No

Are you deaf? ☐ Yes ☐ No Do you use sign language? ☐ Yes ☐ No ☐ NA

Safety

Do you keep fire arms in the home? ☐ Yes ☐ No

If you answered Yes, do you take safety precautions with firearms in the home? ☐ Yes ☐ No ☐ NA

Abuse

Violence and/or sexual abuse is a problem for many people, which is why we routinely screen all patients for violence or abuse in their lives. Are you experiencing violence and/or sexual abuse? ☐ Yes ☐ No

Fall Risk	Clinical Staff: If Yes checked for any Fall Risk question, was Fall Prevention Education given? ☐ Yes ☐ No ☐ NA, give reason _____
Have you fallen in the last year? ☐ Yes ☐ No	
Do you experience forgetfulness or confusion? ☐ Yes ☐ No	
Do you use a walker or cane? ☐ Yes ☐ No	
Depression Screening	Clinical Staff: If Yes checked for either Depression Screening question, the Provider will complete a PHQ-9 screening.
Over the past 2 weeks, have you experienced any of the following:	
Little interest or pleasure in doing things ☐ Yes ☐ No	
Feeling down, depressed or hopeless ☐ Yes ☐ No	

Advanced Directive

Do you have an Advanced Directive, which is written instructions for your family and health care provider in the event that you cannot make a decision about your care? ☐ Yes ☐ No

Would you like information on Advanced Directives? ☐ Yes ☐ No ☐ NA

Clinical Staff: If Yes checked for Advanced Directive, was information given? ☐ Yes ☐ No

Information Given by: _____ Relationship to Patient (if not self) _____ Date _____

Clinical Staff only

Reviewed by:

Provider's Signature (Required) _____ Date & Time (Required) _____