TLC Pediatrics

Health Needs Assessment

Patient Name: _____ Patient Date of Birth: _____

Your Name: _____ Your Relationship to Patient: _____

Preferred Language: _____

		Yes/No
	In the last 12 months, did you or your family ever **eat less than you felt you should** because there wasn't enough money for food?	Y N
	Are you worried that in the next 2 months you **may not have stable housing**?	Y N
	Think about the place you live. Do you have problems with any of the following? **Pests (mice or roaches), mold, no/not working smoke detectors, water leaks, no window guards**.	Y N
	In the last 12 months, has the **electric, gas, oil, or water company threatened to shut off your services** in your home?	Y N
	In the last 12 months, have you or your family ever had to go without health care because you didn't have **a way to get there**?	Y N
	Are you or your family worried about feeling **safe in your home**?	Y N
	Do you have concerns about your/your child's **learning or behavior in school, preschool, or daycare**?	Y N
	Do you feel that you need more **support from other people or programs** to help you care for yourself or your family?	Y N
	Do you need help **understanding your or your child's healthcare needs** (diagnosis, medications, plan, etc.)?	Y N
	In the last 12 months, was there a time when your child needed to see a doctor or get medications or supplies **but could not because of cost**?	Y N
	Did you or your child **miss school or work** because of a health problem that could have been avoided?	Y N

	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	Y N

Comments:

Adapted from the Health Leads Recommended Screening Tool, www.healthleadsusa.org