

Sample Needs Assessment

Identifying Information

Client's name: _____

Date of Visit: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____
_____ (city) _____ (zip) _____

Phone: (home) _____ (office) _____

Marital Status: _____

Spouse's name (if applicable): _____ D.O.B.: _____

Level of Education: _____

Employer: _____

Emergency Contact Person: _____ Phone #: _____

Reason for visit: _____

Social Information

Do you have transportation to the health center? Y N

Please explain: _____

Do you need child care? Y N

Please explain: _____

Do you have a faith affiliation? Y N

Please explain: _____

Have you recently had any changes in your:

Marital status Y N

Please describe: _____

Employment Y N

Please describe: _____

Residence Y N

Please describe: _____

What language do you speak at home? _____

Do you need interpreter services? Y N Language? _____

Sample Needs Assessment

Medical Information

In the past 6 months:

Have you been treated by a physician for any illnesses? Y N

Please explain: _____

Do you have any chronic illnesses? Y N

Please explain: _____

How much do you exercise? Y _____ (minutes per week) N

Do you smoke? Y _____ (amount each day) N

Are you currently taking any medications? Y N

Please explain: _____

Plan of Care:

Date:

1. Appointments needed

- a. _____
- b. _____
- c. _____

2. Interpreter services scheduled? Y _____ (Language) N

3. Transportation _____

4. Referrals

- a. Housing _____
- b. Food bank _____
- c. Smoking cessation _____
- d. Health education classes _____
- e. Other _____
- f. Other _____

5. What is patient's support system?

6. Follow up needed:

