PATIENT NEEDS ASSESSMENT

Patient Name _____ **Date** _____

LIVING ARRANGEMENTS

Are you Homeless? ____ Yes _____ No

How many people live in your household? _____

Do you live _____ with parent(s)/guardian(s)? _____ with relatives? _____With roommate?

Do your children live with you? _____

PEOPLE LIVING IN HOUSEHOLD?

Name	**Relationship**	**Age**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

****

EMERGENCY CONTACTS [Other adults or relatives we can contact if we are unable to reach you]

1. Last Name _____ First Name _____

Address _____ Apt. _____

City _____ State _____ Zip Code _____

Home Phone [including Area Code] _____

Cell Phone [including Area Code] _____

2. Last Name _____ First Name _____

Address _____ Apt. _____

City _____ State _____ Zip Code _____

Home Phone [including Area Code] _____

Cell Phone [including Area Code] _____

3. Last Name _____ First Name _____

Address _____ Apt. _____

City _____ State _____ Zip Code _____

Home Phone [including Area Code] _____

Cell Phone [including Area Code] _____

4. Last Name _____ First Name _____

Address _____ Apt. _____

City _____ State _____ Zip Code _____

Home Phone [including Area Code] _____

Cell Phone [including Area Code] _____

5. Last Name _____ First Name _____

Address _____ Apt. _____

City _____ State _____ Zip Code _____

Home Phone [including Area Code] _____

Cell Phone [including Area Code] _____

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GOALS [List three goals that you/your family want to achieve within the next six months.]

1.

2.

3.

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ADDITIONAL NEEDS

Please check any of the following needs currently or recently experienced by you/your family:

_____ **Heat/Gas**

_____ **Electricity**

_____ **Water**

_____ **Food**

_____ **Social Support**

_____ **Education (School enrollment, Tutoring, Special Education advocacy)**

_____ **Employment**

_____ **Housing**

_____ **Emotional Issues**

Please explain any needs you indicated above.

_____ _____

Patient Signature Date

Form Completed By _____
Name/Signature

Position _____

Date _____

Referrals Made_____

ALL REFERRALS MUST BE PRECEDED BY HIPAA-COMPLIANT CONSENT FORMS.