Adult Health Assessment

Please complete this form and send it back in the pre-paid envelope. Or you can complete this form online at www.MCCofFL.com. If you need help filling out this form, please call us at 800-327-8613 (TTY 711).

Magellan Complete Care, your health plan, wants to help you feel better and enjoy a healthy life.

These health questions will help us to better understand how you are feeling. It will help us know what services and resources you will need to stay healthy and feel well. The questions will take you about 15 minutes to complete.

As your health plan it is key that we work very closely with your doctors. We will make sure you get the care you need. If you give us the OK, we can share this information with your doctors. This will make sure you get good care and help your doctors talk to each other. Without your OK, we will not share any information with anyone.

Do you agree for us to share this information with your doctors? ○ Yes ○ No

Fields mark with an * are required. Date completed: _____

About You

*Enrollee's Name *Medicaid ID #

*Date of Birth Age

What language do you, your family, or caregiver speak? Race/Ethnicity

*Sex: Male Female *Date of Enrollment Guardian

*Address

*Home Phone # Cell Phone # Email

Other Insurance:

○ Medicare ○ Long Term Care ○ Waiver Program ○ Veteran Benefits ○ Other

*Do you have reliable transportation to your medical appointments?

○ Yes ○ No ○ Unsure

*Best day/time to reach you? _____

*Where do you currently live? (select all that apply)

- ○ House
- ○ Apartment
- ○ Assisted living: Name: _____ Contact: _____
- ○ Shelter: Name: _____
- ○ Other: _____
- ○ Supervised
- ○ Homeless

*Who do you live with? (select all that apply)

○ Alone ○ Roommate ○ Adult family ○ Minor children ○ Relative/friend ○ Other

Are you worried you may not have stable housing in the next two months? This could be housing that you own, rent or where you stay with family or friends.

○ Yes ○ No ○ Unsure

Do you have a caregiver or someone we can contact if we can't reach you?

○ Yes ○ No

If yes is selected, please give details: Name: _____ Contact information: _____

If yes, do you give Magellan Complete Care permission to give information to this person?

○ Yes ○ No

Details: _____

_____

About Your Physical Health

*Height (inches): _____ *Weight (lbs): _____

*Compared to others your age, how would you rate your overall health?

○ Poor ○ Not Good ○ Average ○ Good ○ Excellent

*Do you have any concerns about your health or physical well-being?

○ Yes ○ No ○ Unsure

Details: _____

Do you have any of the following conditions:

- ○ Arthritis/Musculoskeletal
- ○ Asthma
- ○ Cancer
- ○ Depression
- ○ Diabetes
- ○ Heart Problems
- ○ Hearing Impaired
- ○ Hepatitis C
- ○ High Blood Pressure
- ○ HIV/AIDS
- ○ Kidney Disease
- ○ Liver Disease
- ○ Schizophrenia
- ○ Sickle Cell Anemia
- ○ Transplant
- ○ Visually Impaired
- ○ Other: _____

Are you currently pregnant? Estimated due date: _____

○ Yes ○ No ○ Unsure

A case manager will be reaching out to you to give more information about our Maternity program.

About Care You Receive

*How many times have you been seen in the Emergency Room in the last 3 months?

○ 0 ○ 1 ○ 2 ○ More than 2

*How many times have you been admitted to the hospital in the last 3 months?

○ 0 ○ 1 ○ 2 ○ More than 2

*How many different prescriptions/medications (other than vitamins) do you take?

○ None ○ 1 – 3 ○ 4 – 7 ○ 8 – 11 ○ 11 or more

*Do you use any medical equipment or other assistive devices?

○ Yes ○ No ○ Unsure

If yes, select type:

○ Wheelchair ○ Brace ○ Lifts
○ Cane ○ Hospital Bed ○ Vent
○ Walker ○ Feeding Aides ○ Nebulizer
○ Reacher ○ Oxygen ○ Other: _____

Do you get assistance with Activities of Daily Living such as dressing, feeding, bathing?

○ Yes ○ No ○ Unsure

If yes, give details:_____

What number best describes how much, during the past week, pain has affected with your general activity?

Does not affect **Completely affects**

0 1 2 3 4 5 6 7 8 9 10

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*What is the name of your primary care provider? PCP Name:_____

○ N/A

*What is the name of your primary behavioral health provider? PBHP Name: _____

○ N/A

*What is the name of your dentist? Dentist Name:_____

○ N/A

Do you see any other healthcare providers? If so what are their names and what do you see them for?

_____

Have you had any of the following done in the last 12 months?

○ Flu Vaccination

Date: _____ Provider Name: _____ Location: _____

○ Pneumonia Vaccination

Date: _____ Provider Name: _____ Location: _____

○ Mammogram (women)

Date: _____ Provider Name: _____ Location: _____

○ Cervical Cancer Screening (PAP test)

Date: _____ Provider Name: _____ Location: _____

○ Colorectal Cancer Screening

Date: _____ Provider Name: _____ Location: _____

About Your Lifestyle

*How many meals do you eat on a regular day?

○ Fewer than 3 ○ 3 ○ 4 to 6 ○ More than 6

*How often do you eat fast food, processed foods (such as chicken nuggets, hot dogs, bologna) or fried foods?

○ Daily ○ Almost every day ○ Sometimes ○ Never

*Which best describes your use of tobacco products?

○ Never used ○ Current user trying to quit ○ Current user not trying to quit ○ Previous user

*How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?

○ 0 ○ 1 or more

*How many drinks of alcohol do you have in a typical week? (A drink = 12 oz. of beer, a 5 oz. glass of wine, a 12 oz. wine cooler, or a shot of whisky)

○ None ○ 1 to 7 ○ 8 to 14 ○ > 14

*Do you have any substance use concerns?

○ Yes ○ No ○ Unsure

Details: _____

*How would you describe your physical activity/exercise level?

○ High ○ Moderate ○ Low

In the past 4 weeks, how many days did you miss from work or school because of problems with your physical or mental health? (Please include only days missed for your own, not someone else's health.)

○ None ○ 1 to 2 times ○ 3 to 4 times ○ 5 or more times

During the past 7 days, how much did your physical or mental health affect you being able to do things at work or at school?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

About Your Safety

*Do you keep your doors locked at night?

○ Yes ○ No ○ N/A

*Do you keep emergency supplies in your home (such as a first aid kit and canned food)?

○ Yes ○ No ○ N/A

Details: _____

*Do you wear a seatbelt when traveling in a motor vehicle?

○ Yes ○ No ○ N/A

*Do you talk or text on the phone while driving?

○ Yes ○ No ○ N/A

About Your Emotional Health

How often do you feel stressed?

○ Never ○ Sometimes ○ A lot ○ All of the time

Over the past 2 weeks, how often have you been bothered by any of the following problems?

*Little interest or pleasure in doing things

○ Not at all ○ Several days ○ More than half days ○ Nearly every day

*Feeling down, depressed or hopeless

○ Not at all ○ Several days ○ More than half days ○ Nearly every day

About Your Future Health

*How important is it to you to make a change to your health right now?

Not sure					**Somewhat sure**					**Very sure**
0	1	2	3	4	5	6	7	8	9	10

*How confident are you about making a change to your health right now?

Not sure					**Somewhat sure**					**Very sure**
0	1	2	3	4	5	6	7	8	9	10

*How ready are you to make a change to your health right now?

Not sure					**Somewhat sure**					**Very sure**
0	1	2	3	4	5	6	7	8	9	10