

Family Care Physicians, P.C.
Anxiety and Depression Institute
Social Determinants of Health

Patient Name: (first & last)

Patient Date of Birth:

Patient Primary Care Physician:

Today's Date:

As your Patient-Centered Medical Home, we are happy to partner with you, to help you and your family in time of need. From the answers below, we maintain a list of trusted community resources that care about you as much as we do.

Please answer the following questions.			
Within the past 12 months have you worried whether your food would run out before you got money to buy more?	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
In the past year, has the utility company shut off your service for not paying your bills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
In the last 12 months, did you skip medications to save money?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
In the last six months, have you ever had to go without health care because you didn't have a way to get there?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do problems getting child care or elderly care make it difficult to work or study?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you need any assistance with finding a local career center or job training?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
I have trouble understanding my doctor's written instructions.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
How often do you feel lonely?	<input type="checkbox"/> Often	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Never
Do you ever feel unsafe in your home or neighborhood?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If you answered yes, would you like to receive assistance with any of these needs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Can we share this information with organization to whom we make referrals to address these needs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	