

Patient Name: _____ DOB: _____ Date: _____

Social Influencers of Health

Whos provided the answers:

Self Aunt/Uncle Brother/Sister Daughter/Son Father
 Grandchild Grandparent Guardian Interpreter Mother
 Mother Niece/Nephew Other Significant Other Spouse

Within the past 12 months we worried whether our food would run out before we got money to buy more.

Never Sometimes Ture Often True Patient Refused

Within the past 12 months the food we bought just didn't last and we didn't have money to get more.

Never Sometimes Ture Often True Patient Refused

How hard is it for you to pay for the very basics like food, housing, medical care, and air conditioning / heating?

Very hard Hard Somewhat hard Not very hard Patient refused

Are you worried that in the next 2 months you may not have stable housing?

Yes No Patient Refused

Do you have access to a variety of food including fruits and vegetables?

Yes No Patient Refused

Within the last 3 months, how many times did you visit the emergency department of your medical care?

Has the lack of transportation kept you from meetings, work, or from getting things needed for daily living?

Yes No Patient Refused

Has lack of transportation kept you from medical appointments or getting medications?

Yes No Patient Refused

How often do you feel lonely or isolated from those around you?

Never Rarely Sometimes Often Always Patient Refused

How often do you have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Never Rarely Sometimes Often Always Patient Refused

Patient Name: _____ DOB: _____ Date: _____

Do you think completing more education or training, like finishing a GEd, going to college, or learning a trade would be helpful to you?

Yes No Patient Refused

Do you need help finding or paying for care for your loved ones? For example, child care or elderly care for an older adult?

Yes No Patient Refused

Are you afraid that you might be hurt by violence in your neighborhood?

Yes No Patient Refused

Are you afraid that you might be hurt by violence in your apartment or home?

Yes No Patient Refused

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

Yes No

Are any of your needs urgent? For example: I don't have food tonight, I don't have a place to sleep tonight.

Yes No