Your Personal Wellness Assessment

Tell us more about you. Your answers to the questions below can help us make sure you get the care that best fits you. Everything you provide will be kept confidential in accordance with HIPAA and will not change the care you now receive. If you would like to answer these questions by phone, please call Louisiana Healthcare Connections at 1-866-595-8133 (Hearing loss: 711). Please have your insurance card with you as we will need your Member ID number from the front of the card.

*Indicates a required question

Member Information

*Member Name (Last, First)

*Member ID *Date of Birth (MMDDYYYY)

*Preferred Phone Number ( ) –

*Email Address

*In general, how would you rate your health? Excellent Very Good Good Fair Poor Unsure

Do you have a doctor or health care provider? Yes No Unsure

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

None One time Two times Three or more times Unsure

How many times have you been in the Emergency Department in the last 3 months?

None One time Two Times Three or more times Unsure

*Have you ever been told by a doctor or health care provider that you have any of these conditions?

Yes No Unsure (If yes, check all that apply)

Arthritis Asthma Cancer Chronic Kidney Disease COPD/Emphysema

Diabetes Type 1 Diabetes Type 2 Pre-Diabetes Heart Disease Hepatitis High Blood Pressure

High Cholesterol HIV Learning Disability Sickle Cell Disease (not trait) Stroke Transplant

Do you have any other conditions not listed above?

How many medicines are you currently taking that were prescribed by your doctor or health care provider?

0 Prescriptions 1-3 Prescriptions 4-7 Prescriptions Greater than or equal to 8 Prescriptions Unsure

* **In the past two months have you been living in stable housing that you own, rent, or stay in as part of a household? Yes No Unsure

* During the past month, have you often been bothered by feeling down, depressed, or hopeless?

Yes No Unsure

Are you actively receiving treatment for a mental health condition?

Yes No Unsure

General Information

*Assessment Completion Date (MMDDYYYY)

*Assessment Completed By (Name)

*Relationship to member Self Member Representative with permission Parent/Guardian Other

**Reprinted with permission from the copyright holder, the American Public Health Association. Montgomery AE, Fargo JD, Byrne TH, Kane V, Culhane DP. Universal screening for homelessness and risk for homelessness in the Veterans Health Administration. American Journal of Public Health. 2013; 103 (S2): S201–S211. Permission obtained.

Rev. 01 10 2019
XX-HRSS-0000