



# Your Personal Wellness Assessment

Tell us more about yourself. 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 Care1st Member Services at **1-866-560-4042** (TTY: **711**). Please have your member identification (ID) 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

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

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