Catholic Health Services of Long Island
At the heart of health

Siena Proactive Internal Medicine – Smithtown

Patient Name: _____ Patient's Date of Birth: _____
(Please Print)

General Care Management – Patient Level - **PLEASE CIRCLE ANSWERS**

1. **Assessment completed with:** children - family - paid caregiver - parents – Patient – spouse/significant other
2. **Enrolled in care management program:** Yes – No
3. **Primary Care Giver:** friend – family member – parent/legal guardian – self – significant other – caregiver – other
4. **Living Arrangement:** alone – caregiver – family members – foster care – foster parent – friends – parent/legal guardian – significant other – multiple residents
5. **Employment Status:** employed but on leave for health reasons – employed (or self-employed) – not employed – retired
6. **Support System:** none – case manager – community organization – counselor – family – friends – home care staff – neighbors – paid help - parents – religious organization – shelter – spouse/partner – twelve step group
7. **Family conflict:** Yes – No
8. **Type of residence:** apartment – assisted living – group home – homeless – mental health residence – nursing home – one-story home – private residence – two-story home
9. **Home care services:** Yes – No
10. **Equipment used at home:** none – cane – walker – bedside commode – tub seat – oxygen/respiratory treatment – wheelchair – hospital bed
11. **Communication device:** Yes – No
12. **Financial problems:** Yes – No
13. **Transportation issues:** Yes – No
14. **Transportation means:** accessible car – caretaker – family – friend – public transportation – public transportation taxi – regular car – self – ambulette
15. **Communication and other barriers:** no communication barriers – reading barrier – writing barrier – cultural barriers – auditory barriers – cognitive barriers
16. **Bed or wheelchair confined:** Yes – No
17. **Diet:** celiac – diabetic diet – low cholesterol – low saturated fat – other diet – regular – low sodium
18. **Other Health Risks:** a change in medication – none – obesity – sedentary lifestyle – smoking/tobacco exposure – lack of dental/oral care
19. **Exercise:** yes – not currently exercising – unable to exercise
    a. **Minutes per day:** _____
    b. **Times per week:** _____
    c. **Type of exercise:** _____
20. **Inadequate activity/exercise:** Yes – No
21. **Medication adherence:** Yes – No
22. **Experiencing side effects from current medications:** Yes – No
23. **History of falls in last 6 months:** Yes – No
24. **Difficulty keeping appointments:** Yes – No
25. **Family aware of the patient's advance care planning wishes:** Yes – No
26. **Religious or spiritual beliefs that impact treatment:** Yes – No
27. **Chronic pain:** Yes – No
    a. **Location of chronic pain:** _____
    b. **Chronic pain timing:** intermittent – constant
    c. **Chronic pain severity:** 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 - 9 – 10
    d. **Limitation of routine activities due to chronic pain:** none – mild – moderate – severe