

COMMUNITY HEALTH ASSESSMENT

I. Demographic Guide

1. Gender:
 Male Female

2. Age: (RECORD IN YEARS)

3. What is your racial or ethnic identity?
 White
 African American
 Native American
 Asian, Pacific Islander
 Two or more races
 Hispanic
Other: _____ (please specify)

4. What is your level of education?
 High School diploma or GED
 Technical/ Junior college
 Some undergraduate
 Four year degree
 Professional or Graduate School

5. What is your current employment status?
 Employed full-time
 Employed part-time
 Retired
 Unemployed- looking for work
 Unemployed for health or disability reason
 Caring for other family at home
 Student or Full-time homemaker
 Never worked/don't want to work
Other _____ (please specify)

6. What is your marital status?
 Never married
 Married/spouse living
 Separated/divorced
 Widowed
 Single with partner/companion in household
Other _____ (please specify)

II. Individual Assessment of One's Health & Health Related Quality of Life

1. Would you say that in general your health is :
 Excellent Very good Good Fair Poor
2. How many days during the past 30 days was your physical health not good?
_____ days
3. How many days during the past 30 days was your mental health not good?
_____ days
4. During the past 30 days for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, school, or recreation? _____ days
5. How would you rate the overall physical health of other members in the household?
 Excellent Good Average Fair Poor

III. Utilization of Health Care Services

Most Recent Physician Visit

1. On the average, how often do you visit the doctor, HMO, or clinic?
 Less than once a year
 Yearly
 More than once a year, less than once a month
 Monthly
 More than once a month, less than once a week
 Weekly
 More than once a week
2. About how often do you visit the dentist?
 Less than once a year
 Yearly
 More than once a year, less than once a month
 Monthly
 More than once a month, less than once a week
 Weekly
 More than once a week
3. Do you have a doctor or a nurse who you see regularly?
 Yes **(ASK #5)**
 No **(ASK #4)**
 Not sure/ Don't know: skip to #4
4. **IF NO**, where would you go to get care if you were to get sick? **(Check all that apply)**
 Private Doctor's office
 HMO
 Hospital emergency room
 Hospital outpatient health center

- Company/industrial health center
- Public health center
- Neighborhood health center
- Ambulatory surgery center
- Urgent Care Center
- Chiropractor
- School-based center
- Other _____ (please specify)

5. If you are currently receiving care from a doctor or nurse, where do you go to receive care?

- Private Doctor's office
- HMO
- Hospital emergency room
- Hospital outpatient health center
- Company/industrial health center
- Public health center
- Neighborhood health center
- Ambulatory surgery center
- Urgent Care Center
- Chiropractor
- School-based center
- Other _____ (please specify)

6. Were you or any other person in your household hospitalized during the past 12 months?

- Yes No Don't know

7. Did you or any other member of your household require outpatient surgery during the past 12 months?

- Yes No Don't know

8. Did you or any member of your household use the services of a hospital emergency room or a neighborhood emergency center during the past 12 months?

- Yes No Don't know

9. Did you or any member of your household have to be admitted to a nursing home for any period of time during the past 12 months?

- Yes No Don't know

10. Did you or any member of your household have to use the services of a home health care provider during the past 12 months?

- Yes No Don't know

IV. Access and Barriers to Care

1. In general, how would you rate the health care services that you and the members of your household have received in this community?

- Superior

- Above average
- Average
- Below average
- Very bad
- Don't know

2. In the past year, have you, or any member of your family, had difficulty obtaining the services of a doctor? Which person?

- Yes No **(SKIP TO #4)** Don't know

3. **If yes, what difficulties? (CHECK ALL THAT APPLY)**

- No doctor in area
- Lack of money
- Insurance does not cover
- No transportation
- Appointment not available/doctor won't take new appointments
- Doctor won't take Medicare
- Doctor won't take Medicaid
- Language barrier
- No child care
- Have to wait too long
- Other _____ (please specify)

4. In your neighborhood, what are the biggest problems that keep people from getting health care?
(Check all that apply)

- No transportation available
- No health insurance
- Inadequate health insurance
- Lack of regular family doctor
- Providers do not accept Medicaid
- Providers are too far away
- No "good" doctors
- Parents can't take time off from work to take children to providers
- People do not know where to go for primary care services
- Waiting times for appointments are too long
- Parents do not think primary care for their children is important
- Provider hours are inconvenient for parents
- Parents fear of child abuse or neglect allegations by providers
- Non-English speaking or hearing impaired parents communications needs are not met by providers.
- Other _____ (please specify)

V. Housing

1. What type of housing do you live in?

- House/home (single family detached)
- Condominium
- Apartment/duplex

- Mobile home
- Boarding/group home
- Public housing
- Other _____ (please specify)

2. How do you feel about your current housing?

- Very satisfied
- Satisfied
- Sometimes satisfied, sometimes dissatisfied
- Dissatisfied
- Very dissatisfied

Please indicate if you agree strongly, agree, disagree, or disagree strongly.

1. The neighborhood where I live is a good neighborhood to live in.

- Agree strongly
- Agree
- Undecided
- Disagree
- Disagree strongly

2. I feel safe in my neighborhood when I am out in the daytime

- Agree strongly
- Agree
- Undecided
- Disagree
- Disagree strongly

3. I feel safe in my neighborhood when I am out at night

- Agree strongly
- Agree
- Undecided
- Disagree
- Disagree strongly

4. My house/apartment/trailer needs a lot of repair work

- Agree strongly
- Agree
- Undecided
- Disagree
- Disagree strongly

5. In winter I am able to keep my home comfortably warm.

- Agree strongly
- Agree
- Undecided
- Disagree
- Disagree strongly

6. Does your home contain any of the following household aids?

(Check all that apply)

- Bathtub bars
- Telephone amplifier
- Safety plugs for electrical sockets
- Enlarged shower door
- Locks for cabinets with household chemicals or medicines
- Specialized hospital bed
- Chair lift for stairs
- TDY/TTY telephone assistance
- Fire extinguisher
- Lifeline emergency response system
- Smoke detector
- Carbon monoxide detector
- Fire escape
- Ramps

7. Have you or anyone in your household done any of the following things to make you feel safer in your home?

(Check all that apply)

- Bought dog for protection
- Installed strong locks on door
- Installed bars on windows
- Keep a weapon other than a gun/firearm
- Keep a gun or firearm
- Joined a neighborhood crime watch
- Installed a security/alarm system

VI. Transportation

1. Does lack of transportation prevent you or any other household member from doing any of the following things? **(Check all that apply)**

Going grocery shopping	
Getting medical care	
Getting to social service agency (i.e. social security)	
Getting to work, school, or volunteer activities	
Getting to meal sites	
Visiting family/friends	

VII. Risk Factors and Health Status Indicators Smoking

2. What is your smoking status?

- Smoker
- Ex-Smoker
- Never smoked

(IF YOU ANSWERED A OR B)

How many cigarettes per day _____

How many pipes/cigars per day _____

How old were you when you first started smoking cigarettes regularly? _____ age

Non-Seat Belt Use

3. How often do you use seatbelts when you drive or ride in a car?

Would you say?

Always Nearly always Sometimes Seldom Never

(IF HOUSEHOLD HAS CHILDREN 17 OR YOUNGER)

A. How often do your children use seatbelts or car safety seats when they ride in a car?

(Car safety seats for children under 5 years old)

Would you say

Always Nearly always Sometimes Seldom Never

Sedentary Lifestyle

B. How often do you exercise or participate in an active physical sport such as running, jogging, swimming, bicycling, power walking, etc.?

One or more times each week

Less than one time per week

Not at all

C. Which of the following best describes the level of physical effort in your work or daily activities?

Light – such as office work, driving, sitting

Moderate – such as housework, carpentry, walking

Heavy – such as pushing or carrying heavy objects

Hypertension

D. Have you ever been told by a doctor, nurse, or someone else that you/they have high blood pressure?

Yes

No

Don't know/not sure

Alcohol Use

E. Have you had any alcoholic beverages during the past 12 months?

Yes

No

Don't know/not sure

F. **IF YES**, how often did you drink any alcoholic beverages in the past 12 months, on the average?

Once a week or less

Two to five times a week

More than five times a week

Never

Drug Use

G. Have you or any member of you household ever complained or worried that anyone in your household might have a problem with: **(Check all that apply)**

Alcohol (beer, wine or liquor)

Marijuana

- Hallucinogens
- Cocaine/Crack
- Methamphetamine
- Heroin
- Prescription drugs

Driving

- H. On the average, how close to the speed limit do you usually drive?
- Within 5 mph of limit
 - 6-10 mph over limit
 - 11-15 mph over limit
 - More than 15 mph over limit

Driving While Impaired

- I. How many times in the last month did you drive or ride when the driver had perhaps too much to drink, or was under the influence of drugs?
 _____ number of times last month

Nutrition and Diet

- J. During the last six months, have you had difficulty getting enough food to eat for any reason?
 Yes No

K. **(Check all that apply)**

a. Trouble in preparing meals	<input type="checkbox"/>
b. Not enough money	<input type="checkbox"/>
c. Trouble getting to and from the store	<input type="checkbox"/>
d. Refusal to eat	<input type="checkbox"/>
e. Other	<input type="checkbox"/>

IX. Disabilities

1. Are there any members of your household that need assistance in daily activities? (i.e. getting dressed, bathing feeding self, toileting, or getting in/out bed.)
- Individual is 18 or older
 - No **(IF NO, SKIP TO QUESTION 4)**
 - Individual is 17 or younger

(IF YOU ANSWERED A OR C)

2. Is formal help used? (Formal help is considered any assistance which is paid for.)
- Yes No Don't know
3. Do you or any other person in this household have a physical, mental or other health condition that has lasted for 6 or more months and which:
- Limits the kind or amount of work this person can do at a job or at school?
 Yes No
- Prevents this person from working at a job or attending school?

___ Yes ___ No

4. Because of a health condition that has lasted for 6 or more months, do you or any other person in this household have any difficulty:

Going outside the home alone, for example, to shop or visit a doctor's office?

___ Yes ___ No

Taking care of his or her own personal needs, such as bathing, dressing, or getting around inside of the home?

___ Yes ___ No

X. Mental Health

1. Right now, how do you feel about your life as a whole?

___ Very satisfied

___ Satisfied

___ Sometimes satisfied, sometimes dissatisfied

___ Dissatisfied

___ Very dissatisfied

2. During the past few weeks, did you have any problems with:

	Yes	No	Often	Sometimes	Rarely
a. Falling asleep or staying asleep					
b. Feeling afraid					
c. Having a poor appetite					
d. Feeling like crying					
e. Feeling depressed or lonely					
f. Getting upset with people around you					

3. Have you suffered a serious personal loss or misfortune in the past year?

(For example, a job loss, disability, divorce, separation, jail term or death of a close person)

___ Yes, one serious loss ___ Yes, two or more serious losses ___ No

4. Do any household members have any of the following problems: **(Check all that apply)**

Mental Retardation	
Serious Emotion Disturbances	
Developmental disabilities	
Autism	

XI. Violence/Victimization

1. During the past year, have you or any member of your household experienced any of the following problems?

___ Yes ___ No ___ Don't know

(Check all that apply)

Discrimination because of age, race, gender or disability	
Victim of crime against property	
Victim of violent crime against person	
Financial exploitation or sales investment hoax	
Any kind of physical abuse from someone close to you	

XII. Health Insurance

1. Do you have any medical insurance coverage if any health problems arise?

Yes No

What kind?

- Provided by employer
- Privately purchased plan
- Covered under spouse or parent's insurance
- Medicare
- Medicare Supplemental (Medigap)
- Medicaid
- Long term care
- Other _____ (please specify)

XIII. Household Income

1. Considering all sources of income for everyone in your household, what is your before tax monthly income? **(REFER TO MONTHLY FIGURES.)**

	1 person	2 persons	3 persons	4 persons	5 persons	6 persons	7 persons	8 persons	9 or more persons
	Annual (monthly)	Annual (monthly)	Annual (monthly)	Annual (monthly)	Annual (monthly)	Annual (monthly)	Annual (monthly)	Annual (monthly)	Annual (monthly)
#1	5,585 (465)	7,565 (630)	9,545 (795)	11,525 (960)	13,505 (1,125)	15,485 (1,290)	17,465 (1,455)	19,445 (1,620)	21,425 (1,785)
#2	8,378 (698)	11,348 (946)	14,318 (1,193)	17,288 (1,441)	20,258 (1,688)	23,288 (1,936)	26,198 (2,183)	29,168 (2,431)	32,138 (2,678)
#3	11,170 (931)	15,130 (1,261)	19,090 (1,591)	23,050 (1,921)	27,010 (2,251)	30,970 (2,581)	34,930 (2,911)	38,890 (3,241)	42,850 (3,571)
#4	13,963 (1,164)	18,913 (1,576)	23,863 (1,989)	28,813 (2,401)	33,763 (2,814)	38,713 (3,226)	43,663 (3,639)	48,613 (4,051)	53,563 (4,464)
#5	16,755 (1,396)	22,695 (1,891)	28,635 (2,386)	34,575 (2,881)	40,515 (3,376)	46,455 (3,871)	52,395 (4,366)	58,335 (4,861)	64,275 (5,356)

A) Family Size _____ persons B) Income Category _____

(Choose #1, #2, #3, #4 or #5)

Are any household members receiving unemployment or disability?

Yes No

XIV. Children's ADLs

The following items are about activities your child or youth might do during a typical day. Please check if any of your children physical health limits his/her ability to do these activities compared to other children their age?

	Child 1	Child 2	Child 3	Child 4	Child 5
Bathing or dressing himself					
Going to school					
Completing schoolwork					
Walking one block					
Walking several blocks					
Vigorous activities, such as playing sports					

XV. Ending:

Now that I have completed all the questions. I need to record your street address and zip code to help us organize the report.

_____ Street Address

_____ Zip Code

IF YOU DO NOT WISH TO GIVE YOUR ADDRESS, CAN YOU GIVE TWO MAJOR STREETS NEAR YOUR HOME?

_____ AND _____

