

Zip Code: _____

Age: _____

Insured

No Insurance

Medicaid

Medicare

Race / Ethnicity

- White
 Asian
 Black or African American
 Native Hawaiian or Pacific Islander
 Hispanic, Latino, or Spanish Origin
 Indian/Alaskan Native
 Mixed Race

Gender Male Female

Social Needs and Health Behaviors Questionnaire

Please answer the questions below about things that can affect your health. We want everyone to have a safe and healthy environment so we're asking about the challenges they face. If there's a problem, we may be able to help. This is not required. You don't have to answer any questions you don't want to.

Your basic needs

Today or in the past year, have you or someone in your household had to **go without** any of the following?

- | | |
|---|--|
| <input type="checkbox"/> Food | <input type="checkbox"/> Medications |
| <input type="checkbox"/> Rent or mortgage payment | <input type="checkbox"/> Healthcare (such as from a doctor, clinic, or hospital) |
| <input type="checkbox"/> Utilities (such as electricity, water, internet, or phone) | <input type="checkbox"/> Mental health services (such as treatment for anxiety or depression) |
| <input type="checkbox"/> Feeling safe at home (such as safety from physical or emotional abuse, or theft) | <input type="checkbox"/> Substance use disorder services (such as treatment for drug or alcohol misuse) |
| <input type="checkbox"/> Transportation (such as a car or bus fare) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Education resources (school) | <input type="checkbox"/> I don't have a problem with these issues right now, or I choose not to answer this question |
| <input type="checkbox"/> Dental care | |

Your health behaviors

Physical activity



During the past month, did you do any physical activities for exercise? _____
(Examples: walking, running, gardening, or golf)

About how many days per week? _____

About how many minutes per day? _____

About how intense?

- Easy** (like a casual walk)
 Medium (like a brisk walk)
 Hard (like jogging or running)



During the past month, how many times per week did you do physical activities or exercises to strengthen your muscles? _____
(Examples: push-ups, sit-ups, or weight lifting)



Nutrition

About how many servings of fruits and vegetables do you have per day? _____

How many servings of sugar-sweetened drinks do you have per day? _____

Sleep

About how many hours of sleep do you get per night? _____

Tobacco and alcohol

Do you use tobacco?

Yes _____ No _____

(Examples: cigarettes, e-cigarettes, chew, or cigars)

How many servings of alcohol do you drink per day?

- None
 1
 2 or more

