SOCIAL DETERMINANTS OF HEALTH ASSESSMENT

PATIENT NAME _____ **DATE OF BIRTH** _____

FOOD		
Within the past 12 months, did you worry that your food would run out before you got to buy more?	Yes □	No □
Within the past 12 months, did the food you bought just not last, and you did not have the money to buy more?	Yes □	No □
HOUSING/UTILITIES		
Within the past 12 months, have you stayed outside?	Yes □	No □
Within the past 12 months, has you stayed in a car?	Yes □	No □
Within the past 12 months, have you stayed in a tent?	Yes □	No □
Within the past 12 months, have you stayed in an overnight shelter?	Yes □	No □
Within the past 12 months, have you temporarily stayed in someone else's home?	Yes □	No □
Are you worried about losing your housing?	Yes □	No □
In the last 12 months , have you been able to get utilities (heat, electricity) when it was really needed?	Yes □	No □
TRANSPORTATION		
Within the past 12 months, has a lack of transportation kept you from medical appointments?	Yes □	No □
Within the past 12 months, has a lack of transportation kept you from doing things needed for daily living?	Yes □	No □
EDUCATION		
Do you want help with school (ie getting a high school diploma, GED, or equivalent)?	Yes □	No □
Do you want help with training (ie starting or completing job training)?	Yes □	No □
Do you speak a language other than English at home?	Yes □	No □
INTERPERSONAL SAFETY		
Do you feel emotionally unsafe where you currently live?	Yes □	No □
Within the past 12 months, have you been humiliated or emotionally abused by anyone?	Yes □	No □
Do you feel physically or emotionally unsafe where you currently live?	Yes □	No □
Within the past 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by anyone?	Yes □	No □
HEALTHCARE		
In the past month, did physical health keep you from doing you usual activities (work, school, or hobbies)?	Yes □	No □
In the past month, did mental health keep you from doing your usual actiities (work, school, or hobbies)?	Yes □	No □
In the past 12 months, was there a time that you need to see a doctor, but could not because it cost too much?	Yes □	No □
EMPLOYMENT		
Do you have a job or any other source of income?	Yes □	No □
IMMEDIATE NEED		
Do you have food tonight?	Yes □	No □
Do you have a place to sleep tonight?	Yes □	No □
Are you afraid you will get hurt if you go home tonight?	Yes □	No □
Would you like help with any of the needs identified?	Yes □	No □

Patient Signature _____ **Date** _____