Doctors Care
Accessible Care for the Underserved

Please fill one form out for every adult covered under Doctors Care.

Client Name _____Date of Birth_____

Today's Date_____

How are you feeling about yourself and your life?

PLEASE CIRCLE YES OR NO:

1. Do you have a serious problem with sleeping well?	YES	NO
2. Do you feel really down, nervous, upset, sad or hopeless a lot of the time?	YES	NO
3. Are there people you live with or people who are involved in your life who are *really* stressing you out?	YES	NO
4. Do you sometimes feel like you want to harm yourself or others?	YES	NO
5. Do you use recreational drugs?	YES	NO
6. Have you ever felt like you should cut down on your drinking or drug use?	YES	NO
7. Have people annoyed you by criticizing your drinking or drug use?	YES	NO
8. Have you ever felt bad or guilty about your drinking or drug use?	YES	NO
9. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?	YES	NO
10. Have you recently been thinking you would like to talk to someone about your life or any problems you may have?	YES	NO
11. Have you ever wanted help in cutting down your spending, smoking, eating or other habits?	YES	NO

For Office Use Only Patient ID: _____ Date Received: _____ Screener Initials: _____

General Health Questions

*Please note that answers to these questions will **not** affect you Doctors Care eligibility.*

PLEASE CIRCLE THE APPROPRIATE RESPONSE:

1. Please rate your overall level of health.
   Poor Fair Good Excellent

2. How limited are your daily activities due to your health problems?
   Very limited Somewhat limited Slightly limited Not limited

3. How much do your health problems harm your ability to stay employed?
   Completely A great deal Somewhat Not at all

4. What level of pain do you experience daily?
   Severe Moderate Minimal None

5. How much energy do you have compared to other people your age?
   Much less Somewhat less About the same Somewhat more Much More

6. Please rate your overall level of emotional well-being.
   Poor Fair Good Excellent

7. How limited are your daily activities due to your emotional health issues?
   Very limited Somewhat limited Slightly limited Not limited

8. How much do your emotional issues harm your ability to stay employed?
   Completely A great deal Somewhat Not at all

IF YOU ARE *SUBMITTING A NEW APPLICATION*, PLEASE ANSWER THE FOLLOWING:

Who are your current medical providers with whom you hope to continue seeing under Doctors Care?

Provider's Name	Practice Name and/or Address	Provider's Phone Number

***We cannot guarantee that you will be able to stay with these providers, but we will try to make it happen.*

ADDITIONAL COMMENTS OR SUGGESTIONS: (OPTIONAL)