Patient Assessment Questionnaire

Patient Name: _____

Date: _____

Facility: _____

Contact Name: _____

Contact number: _____ ex. _____

☐Social Worker ☐Case Manager ☐Administrator

MediCal / MediCare	Does patient have behavioral issues?
Is patient ambulatory?	Does patient have insomnia/depression?
Can patient climb stairs?	Patient discharge date?
Does patient need assistance transferring?	Is there a payee?
Is patient on prescription medication?	Does patient need any physical therapy?
Is patient on psychotropic medication?	Is patient homeless?
Does patient smoke?	Does patient have pets?
Who did patient live with previously?	Are family members involved in care?
How long at previous location?	Does patient have money to move in now?
What is patient's monthly income?	Doe patient have valid ID?

Patient Age: _____ Room number: _____ Phone number: ( )_____