NAME_____

DOB_____

DATE_____

CHESTER MEDICAL ASSOCIATES

SOCIAL NEEDS SCREENING

DO YOU HAVE DIFFICULTY WITH ANY OF THE FOLLOWING?	Y	N
1.PAYING FOR LIVING EXPENSES	Y	N
2.PAYING FOR UTILITIES	Y	N
3.CONCERN FOR YOUR HOUSING SITUATION, CURRENT OR FUTURE	Y	N
4.GROCERY SHOPPING	Y	N
5.MEAL PREPARATION	Y	N
6.TRANSPORTATION FOR MEDICAL APPOINTMENTS	Y	N
7.TRANSPORTATION FOR NON-MEDICAL APPOINTMENTS	Y	N
8.DO YOU EXPERIENCE FEELINGS OF LONELINESS OR SOCIAL ISOLATION?	Y	N
9.HAS ANYONE, INCLUDING A FAMILY MEMBER, PHYSICALLY HURT YOU?	Y	N
10.HAS ANYONE, INCLUDING A FAMILY MEMBER, THREATENED YOU WITH HARM?	Y	N

PLEASE PROVIDE MORE INFORMATION ON ANY YES ANSWERS.

WOULD YOU LIKE HELP WITH ANY OF THESE NEEDS?