HEALTH NEEDS ASSESSMENT ToDay: _____

Phone number: Email:

Name *Vet: yes / no* *DOB*
Spouse
Children
Address:

CURRENT Medical Plan:_____
Prem:_____, _____, _____Ded/co-ins_____Max_____
Medicare: YES / NO
Diagnosis or Treatment within 12-36 months: YES/ NO

Chronic conditions: YES / NO

Medicines: YES / NO

Medical Doctors:

Specialist:

Mental Health:

How often do you go to the Doctor: 0-1 2-5 6-10 Never
(In a twelve month time)