Clover Health Assessment

We want to help you be as healthy as you can be with healthcare tailored to you. Please complete this survey and send it back in the enclosed postage-paid envelope. You can also complete this survey over the phone by calling 1-888-657-1207 (TTY 711) 8 am–8 pm local time, 7 days a week.*

First Name:	Last Name:

Clover Member ID: | C | P | | | | | | | |

Date of Birth: __ __ / __ __ / __ __ __ __

Today's Date: __ __ / __ __ / __ __ __ __

1. Which of the following best describes where you live? (check one of the following)

- ☐ Private house
- ☐ Private apartment
- ☐ Assisted living facility
- ☐ Homeless
- ☐ Senior housing

2. Who do you live with? (check all that apply)

- ☐ Alone
- ☐ Spouse or partner
- ☐ Other family
- ☐ Friends
- ☐ Hired caregivers

3. In general, how would you rate your health? (check one of the following)

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

4. How would you rate your physical health now compared to 1 year ago? (check one of the following)

- ☐ Much better
- ☐ Slightly better
- ☐ Same
- ☐ Slightly worse
- ☐ Much worse

5. Do you currently smoke or have you smoked in the past? (check one of the following)

- ☐ Current smoker
- ☐ Former smoker
- ☐ Never smoked

6. **How would you rate your emotional health (feeling anxious or depressed) now compared to 1 year ago? (check one of the following)**

☐ Much better ☐ Slightly better ☐ Same
☐ Slightly worse ☐ Much worse

7. **How often do you exercise? (check one of the following)**

☐ Never ☐ Once a month ☐ Once a week ☐ Several times a week

8. **During the past week, how often was the food for your evening meal healthy (such as fresh fruits, fish, and vegetables) instead of unhealthy (such as fried foods, sweets, and "junk food")? (check one of the following)**

☐ Almost always ☐ Most of the time ☐ Some of the time
☐ A little of the time ☐ Almost never

9. **Do you ever need help with self-care and household activities like going to the bathroom, cleaning your home, or shopping?**

☐ Yes ☐ No

10. **Do you use any of the following to help walk or get around? (check all that apply)**

☐ Crutches ☐ Walker ☐ Cane ☐ Wheelchair ☐ Scooter
☐ Other: (please describe)

____

11 **Do you have a fear of falling?**

☐ Yes ☐ No

12. **How many times have you fallen in the past year? (fill in one digit per box)**

☐☐

13. **About how many times have you been to the emergency room in the past year? (fill in one digit per box)**

☐☐

14. In the past 4 weeks, how much bodily pain have you generally had? **(check one of the following)**

☐ No pain ☐ Very mild pain ☐ Mild pain
☐ Moderate pain ☐ Severe pain

15. How often in the past 4 weeks have you been bothered by any of the following problems? **(select the answer that best describes your experience)**

Teeth or denture problems

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Unsteady or dizzy when standing up

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Trouble urinating or wetting

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Trouble thinking or remembering

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

Feeling sad or depressed

☐ Never ☐ Seldom ☐ Sometimes ☐ Often ☐ Always

16. During the past 4 weeks, was someone available to help you if you needed and wanted help? For example, if you: Felt very nervous, lonely, or blue; Got sick and had to stay in bed; Needed someone to talk to; Needed help with daily chores; or Needed help just taking care of yourself. **(check one of the following)**

☐ Yes, as much as I wanted ☐ Yes, quite a bit ☐ Yes, some
☐ Yes, a little ☐ No, not at all

17. How often do you have a drink containing alcohol? **(check one of the following)**

☐ Never ☐ Monthly or less ☐ 2-4 times a month
☐ 2-3 times a week ☐ 4 or more times a week

18. In the past year, have you been treated for any of the following conditions? (check all that apply)

- ☐ Heart disease (heart attack, congestive heart failure/CHF, angina)
- ☐ High blood pressure (hypertension)
- ☐ Irregular heart rhythm (atrial fibrillation)
- ☐ Lung disease (COPD, emphysema, asthma)
- ☐ Diabetes
- ☐ Arthritis
- ☐ Chronic pain
- ☐ Cancer

19. How many different medications do you currently take on a daily basis? (fill in one digit per box)

20. How often are you able to take your medications as prescribed by your doctor? (check one of the following)

- ☐ I do not have to take medicines
- ☐ I always take them as prescribed
- ☐ Sometimes I take them as prescribed
- ☐ I seldom take them as prescribed

21. How confident are you that you can control and manage most of your health problems? (check one of the following)

- ☐ Very confident
- ☐ Somewhat confident
- ☐ Not very confident
- ☐ I do not have any health problems

22. Did someone help you complete this form?

- ☐ No, completed by myself
- ☐ Yes, with help of friend, family, or caregiver

Thank you for completing this survey. Please send it back to us as soon as you can. If you have any questions, please call 1-888-657-1207 (TTY 711) 8 am–8 pm local time, 7 days a week.*

*Between February 15th and September 30th, alternate technologies (for example, voicemail) will be used on the weekends and holidays.