

Client Needs Assessment

First Name		Last Name	
Birthdate		Gender	
Estimated Household Income		ZIP Code	
Does this person use tobacco?		Estimated insurance budget	
Current health plan (Carrier) (Type; ex: ind., group, etc.)		Describe your travel habits	

What is the name of the Primary Care Physician (PCP) that this person sees?		
On average, how many times per calendar year does this person see their PCP?		
List the names and specialties of any other physicians this person sees. Examples include cardiologists, pulmonologists, orthopedic surgeons, etc.	Physician Name	Specialty
List the names and specialties of any mental health providers, including counselors or therapists, that this person sees.	Mental Health Provider Name	Specialty
List any prescriptions this person currently takes.	Prescription Name	Frequency
List the names and specialties of any vision providers this person sees. Examples include optometrists and ophthalmologists.	Vision Provider Name	Specialty
List the names and specialties of any dental providers this person sees. Examples include dentists, endodontists, and orthodontists.	Dental Provider Name	Specialty
What, if any, devices does this person use to aid vision, hearing or mobility?		
Does this person have a family history of heart attack, stroke or cancer?		
What resources do you plan to use to cover your final expenses?		
What resources do you plan to use to cover any long-or-short term care you might need?		