# Opioid Health Home Needs Assessment

Client Name: Client Number:

Phone Number: Email Address:

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**Medical Health:**

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| Yes | No | |
|---|---|---|
| ☐ | ☐ | 1. Any medical issues that need follow-up? |
| ☐ | ☐ | 2. Is the patient pregnant? |
| ☐ | ☐ | 3. Is the patient experiencing pain? |
| ☐ | ☐ | 4. Is the patient prescribed any medication? |
| ☐ | ☐ | 5. Does the patient need a referral to a dentist? |
| ☐ | ☐ | 6. Does the patient need a referral for an eye exam? |
| ☐ | ☐ | 7. Would the patient benefit from getting his/her hearing checked? |
| ☐ | ☐ | 8. Does the patient exercise or participate in any physical activity? |

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Medical health needs identified:

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**Co-occurring Mental Health:**

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| Yes | No | |
|---|---|---|
| ☐ | ☐ | 1. Is the patient currently receiving mental health treatment? |
| ☐ | ☐ | 2. Has the patient previously received any mental health treatment? |
| ☐ | ☐ | 3. Is the patient aware of receiving a mental health diagnosis? |
| ☐ | ☐ | 4. Does the patient indicate any mental health concerns? |
| ☐ | ☐ | 5. Does the patient need a referral for a mental health assessment? |
| ☐ | ☐ | 6. Has the patient experienced or witnessed any trauma in the past or currently? |
| ☐ | ☐ | 7. Does the patient have or need a personal safety plan? |

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Co-occurring health needs identified:

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# Opioid Health Home Needs Assessment

**Activities of Daily Living:**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | 1. Does the patient need emergency shelter? |
| ☐ | ☐ | 2. Does the patient need help in locating and/or maintaining affordable & suitable housing? |
| ☐ | ☐ | 3. Does the patient live alone? |
| ☐ | ☐ | 4. Does the patient have transportation needs? |
| ☐ | ☐ | 5. Does the patient have any physical disabilities impacting daily living? |
| ☐ | ☐ | 6. Does the patient have support services for his/her physical disability? |
| ☐ | ☐ | 7. Does the patient need support meeting basic nutritional needs for self and/or children? |
| ☐ | ☐ | 8. Does the patient need budget and/or credit counseling services? |
| | | 9. Does the patient have any cultural issues, including language which impact daily living? |

Activities of daily living needs identified:

**Family/Relationships:**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | 1. Is the patient's significant others supportive of patient's treatment? |
| ☐ | ☐ | 2. Does the patient have any children? |
| ☐ | ☐ | a. Does the patient need help finding childcare? |
| ☐ | ☐ | b. Does the patient need a pediatric referral? |
| ☐ | ☐ | 3. Is there Department of Human Services (FIA) involvement? |
| ☐ | ☐ | 4. Is there Child Protective Services (CPS) involvement? |
| ☐ | ☐ | 5. Are any minor children living in foster care? |

Family/relationship needs identified:

# Opioid Health Home Needs Assessment

**Educational/Vocational:**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | 1. Is the patient employed or on disability? |
| ☐ | ☐ | 2. Does the patient need assistance obtaining a job? |
| ☐ | ☐ | 3. Is the patient in school or interested in returning? |

Educational/vocational needs identified:

**Legal Issues:**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | 4. Is the patient on probation, parole, or awaiting court proceedings? |
| ☐ | ☐ | 5. Is the patient involved with Drug Treatment Court? |
| ☐ | ☐ | 6. Are there any other legal or civil concerns? |

Legal issue needs identified:

Identify which needs the patient would like to address at this time and incorporate into the treatment plan.

Completed by:_____ Date Completed:_____