# Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)

## PERSONAL HEALTH SURVEY

The survey is voluntary and confidential. Your answers will help in understanding any health problems you may have. Please answer every question as best as you can.

### CLIENT INFORMATION

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<tr>
<th>First Name:</th>
<th>Last Name:</th>
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<tr>
<th>Date of Birth:</th>
<th>Medicaid ID Number (RIN):</th>
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<th>Phone Number:</th>
<th>Alternate Phone Number:</th>
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<th>Best Time to Call (day and time):</th>
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<tr>
<th>Person Completing Form:</th>
<th>Relationship to Client:</th>
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### HEALTH SURVEY (Please only answer the survey questions for the person listed above.)

1. **Do you have any health problems that need to be taken care of quickly?**  
   - [ ] Yes  
   - [ ] No  
   - [ ] Don’t Know  
   
   If YES, what is the health problem? Please explain below.  
   
   

2. **Do you have a primary care doctor?**  
   - [ ] Yes  
   - [ ] No  
   - [ ] Don’t Know  

3. **Do you need help making a doctor's appointment?**  
   - [ ] Yes  
   - [ ] No  

4. **What health problems or medical conditions do you have or have you ever had had in the past?**  
   Check all that apply.  
   
   - [ ] Breathing problems, such as asthma, COPD, emphysema  
   - [ ] Bone or joint problems, such as arthritis, osteoporosis, or back pain  
   - [ ] Cancer  
   - [ ] Dementia  
   - [ ] Developmental Delay/Learning Disability  
   - [ ] Diabetes  
   - [ ] Hearing Problems  
   - [ ] Heart problems, such as chest pain, heart attacks, Congestive Heart Failure  
   - [ ] High Blood Pressure/Hypertension  
   - [ ] High Cholesterol  
   - [ ] HIV/AIDS  
   - [ ] Kidney Diseases/Bladder Problems  
   - [ ] Mental Health Problems  
   - [ ] Pregnancy  
   - [ ] Seizures/Epilepsy  
   - [ ] Stroke  
   - [ ] Substance Use Issues  
   - [ ] Vision Problems  
   - [ ] Other Health Problems (list):  
   

5. **Do you need help with any of following activities?**  
   - [ ] Not applicable  
   - [ ] Bathing/showering  
   - [ ] Brushing teeth  
   - [ ] Getting dressed  
   - [ ] Brushing hair  
   - [ ] Walking  
   - [ ] Climbing stairs  
   - [ ] Using the bathroom  
   - [ ] Getting to school/work  
   - [ ] Getting/making food  
   - [ ] Eating  
   - [ ] Managing medications  
   - [ ] Housework/chores  

6. **Are you current on your vaccinations?**  
   - [ ] Yes  
   - [ ] No  
   - [ ] Don’t Know  

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IM+CANS Personal Health Survey Version 1.4 – 7/1/2018