Name: _____

DOB: _____

OR LABEL

OUTPATIENT EDUCATION NEEDS ASSESSMENT FORM

Behavioral Health Services
Agnesian HealthCare

BHO-0360 (3.07.20) ORDER FROM PRINTING

1 Information provided by:
❑ Patient (Skip #2) ❑ Parent/Legal Guardian ❑ Significant Other (relationship) _____

2. Patient unable to provide information due to:
❑ Medical Instability ❑ Cognitive Impairment ❑ Minor Child - Age: _____

3. What is your primary language? ❑ English ❑ Spanish ❑ Hmong ❑ Other _____
Translator needed: ❑ Yes ❑ No

4. Do you have difficulty reading? .....❑ No ❑ Yes
Do you need glasses for reading? .....❑ No ❑ Yes
Do you need enlarged print for reading?.....❑ No ❑ Yes
Do you have difficulty hearing a normal speaking voice?.....❑ No ❑ Yes
Comments: _____

5. Do you have any changes in concentration? ❑ No ❑ Yes
If yes, please explain: _____

6. Do you have any changes in memory? ❑ No ❑ Yes
If yes, please explain: _____

7. Would you like to learn more about your mental health/substance abuse problems? ❑ No ❑ Yes
How do you prefer to learn new things? ❑ Written materials ❑ Demonstration ❑ Videos ❑ 1 to 1 explanation
❑ Other: _____

8. Are your emotions affected by your health status? ❑ No change ❑ More anxious ❑ More depressed
❑ Other: _____

9. Do you have any religious/cultural practices that may affect your health care choices? ❑ No ❑ Yes
If yes, please explain: _____

10. Do you have any financial concerns that may affect your health care choices? ❑ No ❑ Yes
If yes, please explain: _____

11. Do you have any physical limitations that affect your level of functioning? ❑ No ❑ Yes
If yes, please explain: _____

_____
PATIENT/GUARDIAN SIGNATURE DATE TIME

_____
STAFF SIGNATURE DATE TIME

Assessment