

Self-Care Assessment

YOUTH / YOUNG ADULTS

Young Adults with Neurologic Disorders

Instructions

This document should be completed by youth and young adults (aged 14–25 years old). However, if the youth/young adult is unable to complete this document, their parent or caregiver should fill out “Self-Care Assessment (Parents/Caregiver)”.

Intent

This document will help us to learn:

1. What you already know about your health
2. What you already know about using health care
3. What areas that you think you want or need to learn more about

If you need help filling out the form, please let us know.

Today's Date: _____

Patient Name: _____ **Date of Birth:** _____ **Primary Diagnosis:** _____

Caregiver Name: _____ **Relationship to Patient:** _____ **Are you the main caregiver?** Y I N

Legal Choices for Making Health Care Decisions

- I can make my own health care choices.
- I need some help with making health care choices. Name: _____ Consent: _____
- I have a legal guardian. Name: _____
- I need a referral to community services for legal help with health care decisions and guardianship.

Personal Care

- I care for all my needs.
- I care for my own needs with help.
- I am unable to provide self-care but can tell others my needs.
- I require total personal care assistance.

Self-Care Importance

On a scale of 0 to 10, please pick the number that best describes how you feel right now.

How **important** is it for you to take care of your own health care?

<input type="checkbox"/>										
0 (not important)	1	2	3	4	5	6	7	8	9	10 (very important)

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Self-Care Importance (continued)

How **confident** do you feel about your ability to take care of your own health care?

<input type="checkbox"/>										
0 (not confident)	1	2	3	4	5	6	7	8	9	10 (very confident)

My Health

Please check the box that applies to you right now.

	Yes, I know this	I need to still learn this	I will need help with this
			Who:
I know what medical conditions I have	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what my medications are for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what to do if I have a medical emergency. I have an emergency care plan documented.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take my medicines without someone reminding me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what medicines I should not take.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know what I am allergic to.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can name at least 2 people who can help with my health goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can explain to people how my beliefs affect my care choices.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Using Health Care

Please check the box that applies to you right now.

	Yes, I know this	I need to still learn this	I will need help with this
			Who:
I know or I can find my doctor's phone number.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can make my own doctor appointments.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Before a visit, I think about questions to ask.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a way to get to my doctor's office.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know I should show up 15 minutes before my visit to check in.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Using Health Care (continued)

	Yes, I know this	I need to still learn this	I will need help with this
			Who:
I know where to go or call when my doctor's office is closed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can provide my medical information to healthcare staff (including a summary of my medical history and emergency care plan).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a copy of my plan of care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to fill out medical forms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to ask to be seen by another doctor or therapist.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know where my pharmacy is and what to do if I run out of my medicines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know where to get a blood test or x-rays if the doctor orders them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I carry my health information with me every day (e.g., insurance card, allergies, medications, and emergency phone numbers).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a plan so I can keep my health insurance after 18 or older.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other comments