Survey of Wellbeing and Unmet Health Needs in Homeless Persons **Study ID: _____**
Survey Instrument **Date**: _____

Please fill out this survey to the best of your knowledge. Fill in the blank spaces when it applies to you. Please let us know if you need help answering any of the questions or if you have questions regarding the study.

1. What is your age: _____ years
2. What is your sex assigned at birth (*circle one*): Male Female
3. What is your gender (*circle one*): Man Woman Transgender Other: _____
4. What race are you? *(circle all that apply)*
   1 = African American/Black 2 = Caucasian/White
   3 = Asian 4 = Native American/Eskimo
   5 = Pacific Islander 6 = Unknown/Refused
5. Are you of Hispanic, Latino, or Spanish origin (*circle one*)? Yes No Unknown
6. Are you a veteran (*circle one*): Yes No
7. Are you currently a resident at Shelter House (*circle one*)? Yes No
   a. If YES, how long have you been at Shelter House (*in days*):_____days
   b. If NO, in the past 30 days, how many times have you spent the night at Shelter House? _____ times
8. Is this the first time you have been without your own housing or been homeless (*circle one*)? Yes No
9. How many months have you been without your own housing? _____ months
10. Do you smoke (*circle one*)? Yes No
    a. If YES, how many packs per day? ____ packs
    b. How many years? _____years
11. Do you currently have health insurance (*circle one*): Yes No Do not know
    a. If yes, please list which one(s): _____
    _____
    _____
12. Do you currently have dental insurance (*circle one*): Yes No Do not know

13. Do you currently have vision insurance (*circle one*): Yes No Do not know

14. Do you currently take prescription medications (*circle one*)? Yes No If yes, how many_____

15. Does your insurance include prescription drug coverage (*circle one*)? Yes No Don't know I don't have insurance

16. How would you rate your overall health (*circle one*)?
Poor Fair Good Excellent

17. How would you describe your mental health (*circle one*)?
Poor Fair Good Excellent

18. How would you rate your current insurance coverage for your needs (*circle one*)?
Poor Fair Good Excellent

19. When was the last time you saw any health care provider (*check one*):

☐ In the last 30 days ☐ In the last 6 months ☐ More than 12 months ago
☐ In the last 3 months ☐ In the last 12 months ☐ Never

20. Do you have any chronic, ongoing or serious health care conditions (*circle one*)? Yes No
    a. If so, please list_____
    _____
    b. Are you satisfied with your overall care for these conditions (*circle one)*? Yes No

21. Do you have a primary care physician (*circle one*)? Yes No
    a. If so, when was your last appointment (*fill in month and year*)? _____(month)_____ (year)
    b. Where are they located (*be specific*)? _____

22. In the last 12 months, have you:
    a. Been cared for by a doctor, nurse, or other health care worker but *did not* stay overnight: Yes No
    b. Stayed overnight in the hospital: Yes No
        i. If yes, how many times: _____times
    c. Been seen in the emergency room: Yes No
        i. If yes, how many times: _____times

23. Have you sought care in JOHNSON COUNTY in the last 12 months (*circle one*): Yes No
    a. If yes, where (*check ALL that apply*)?

☐ University of Iowa Hospitals and Clinics (UIHC)
☐ Mercy Hospital
☐ VA (Veterans Affairs) Hospital
☐ Sycamore Health Center
☐ Shelter House Nursing Clinic
☐ Quick Care facility
☐ Mobile clinic
☐ Free Mental Health Clinic/ Community mental health center
☐ Free Medical Clinic of Iowa City
☐ Emma Goldman Clinic
☐ Other (please list all): _____
_____
_____

24. Check which of the following health topics/activities are important to your personal health and/or wellbeing?

☐ Psychiatry/mental health/counseling
☐ Help for substance use/drug use/alcohol use
☐ Dentistry
☐ Health education
☐ Heart health
☐ Smoking cessation
☐ Mindfulness
☐ Disease control
☐ Weight loss
☐ Care for infections
☐ Women's health
☐ Diabetes
☐ Sexually transmitted disease (STD) education/testing
☐ Other, please explain_____
_____
_____

25. Do you have any health needs that are not being met (*circle one*): Yes No
    a. If yes, please explain: _____
    _____

26. Do you have any children (*circle one*): Yes No
    a. If yes, how many children do you have? _____
    b. Is your child/are your children staying with you at Shelter House (*circle one*)? Yes No
    c. Does your child/do your children have health insurance (*circle one*)? Yes No
    d. Does your child/do your children have unmet health care needs (*circle one*)? Yes No

27. What, if anything, makes it difficult for you to be healthy? _____
_____
_____

28. What health care program or service not currently offered at Shelter House would provide the greatest benefit to you? _____
_____
_____