___________________________________'s Care Plan

We are committed to providing you the best healthcare experience possible, and we welcome your feedback. This form will help us understand your health goals.

What matters most to you:

- ☐ Health/Well-being
- ☐ Taking my meds to be healthy
- ☐ Sexual Health
- ☐ Family
- ☐ Friends
- ☐ Finances
- ☐ Job Security
- ☐ Housing
- ☐ Being Content
- ☐ Love
- ☐ Stigma
- ☐ Other ____

What goals do you have in mind?

____

____

____

____

____

How can we help you to acheive your goals?

____

____

____

____

____

I want the provider and nurse working with me to know I have challenges with (select below):

- ☐ Transportation
- ☐ Vision
- ☐ Hearing
- ☐ Mobility
- ☐ English as a second language
- ☐ Other ____

I have issues with my diet:

☐ Yes ☐ No

Comments: ___________________________________

____

____

____

I live:

- ☐ Alone
- ☐ Partner/Spouse
- ☐ Extended Family
- ☐ Other

I learn best by (select below):

- ☐ Reading
- ☐ Talking
- ☐ Seeing pictures or video
- ☐ Listening to a recording
- ☐ Being shown how

Do you have internet access?

☐ Yes ☐ No

Do you have a smart phone?

☐ Yes ☐ No

Do you have a computer?

☐ Yes ☐ No

Can you access the Patient Portal?

☐ Yes ☐ No

Do you know when your next appointment is?

☐ Yes ☐ No

Do you know the names of your care team, including your medical provider, nurse, medical assistant, peer or others?

☐ Yes ☐ No

Do you know what medications you've been prescribed?

☐ Yes ☐ No

If yes, please write the names:

____

____

____

Have you stopped taking your medications?

☐ Yes ☐ No

How long ago? ____________ weeks / months / years *(circle)*

If yes, can you share why?

____

____

Do you know the results of your last viral load lab?

☐ Yes ☐ No

Do you feel empowered to know your lab results?

☐ Yes ☐ No

Do you know the results of other recent lab or health assessments?

☐ Yes ☐ No