

1. Student Health Services Survey

Spectrum Health Kelsey Hospital has received a planning grant to assess the needs of Lakeview Community Schools and the community commitment for school-linked health center services. Your input and feedback will be invaluable in helping them learn more about the needs of our students. Please take the 10 minutes to complete this survey by May 20, 2009.

1. Where do you usually go for health care? (Please check only one)

- Private doctor's office School Based Health Center No place
 Outpatient Clinic Urgent Care I am not sure
 Neighborhood Health Center Emergency Room
 Teen Health Center I do not always go to the same place

Other (please specify)

2. What type of health insurance do you have? (Please check only one)

- I do NOT have health insurance Blue Cross/Blue Shield I do not know
 Medicaid County Health Plan
 MI Child or Healthy Kids Other Private Insurance

3. Have you ever had trouble getting medical services for the following reasons? (Check either YES or NO for each question)

	Yes	No
Health Care Center was not open when I needed it	<input type="radio"/>	<input type="radio"/>
Medical care costs too much money	<input type="radio"/>	<input type="radio"/>
It was too hard to get there/I did not have transportation	<input type="radio"/>	<input type="radio"/>
I had to wait too long to get an appointment	<input type="radio"/>	<input type="radio"/>
I do not like the staff and/or medical provider	<input type="radio"/>	<input type="radio"/>
I am uncomfortable going	<input type="radio"/>	<input type="radio"/>
I am afraid my visit may not be kept confidential (private)	<input type="radio"/>	<input type="radio"/>
It was hard to find a special clinic for my age group	<input type="radio"/>	<input type="radio"/>
I just did not get around to it	<input type="radio"/>	<input type="radio"/>

Other (please explain)

4. When was the last time you saw a doctor or nurse for a physical exam or check up when you were NOT sick, hurt or pregnant? (Please check only one)

- During the last 12 months 3-4 years ago Never
 1-2 years ago More than 4 years ago I do not remember

5. During the last 12 months have you done any of the following things? (Check either YES or NO for each question)

	Yes	No
Seen a dentist	<input type="radio"/>	<input type="radio"/>
Had an eye exam	<input type="radio"/>	<input type="radio"/>
Seen a doctor or nurse practitioner	<input type="radio"/>	<input type="radio"/>
Seen a counselor	<input type="radio"/>	<input type="radio"/>

6. To the best of your knowledge, have you had any of the following health problems within the last 12 months? (Check either YES or NO for each question)

	Yes	No
Diabetes	<input type="radio"/>	<input type="radio"/>
Sexually transmitted disease (STD or VD)	<input type="radio"/>	<input type="radio"/>
Pregnancy	<input type="radio"/>	<input type="radio"/>
HIV infection or AIDS	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>
Dental problems (tooth problems)	<input type="radio"/>	<input type="radio"/>
Vision or eye problems	<input type="radio"/>	<input type="radio"/>
Emotional Problems	<input type="radio"/>	<input type="radio"/>

Other health problem or disability (please explain)

7. Have you had any of the following health care needs within the last 12 months? (Check either YES or NO for each question)

	Yes	No
Illnesses such as colds, ear infections, sore throat, headaches, cramps	<input type="radio"/>	<input type="radio"/>
Care for ongoing illnesses such as asthma, diabetes, seizures	<input type="radio"/>	<input type="radio"/>
Sports, camp, or school physical	<input type="radio"/>	<input type="radio"/>
Immunizations (shots)	<input type="radio"/>	<input type="radio"/>
Needed to go to the emergency room	<input type="radio"/>	<input type="radio"/>
Stayed overnight in the hospital	<input type="radio"/>	<input type="radio"/>
Birth control, or STD diagnosis or treatment	<input type="radio"/>	<input type="radio"/>
Pregnancy	<input type="radio"/>	<input type="radio"/>
Injuries	<input type="radio"/>	<input type="radio"/>
Feeling sad or hopeless, lots of stress in your life, family problems	<input type="radio"/>	<input type="radio"/>
Problems or worries about drugs or alcohol	<input type="radio"/>	<input type="radio"/>

Other health problem or disability (please explain)

8. Who do you live with? (Please check only one)

- Mother and Father Grandparent Your Boyfriend or Girlfriend
 One Parent Other Relative
 One Parent and Step Parent Other Adult

Other (please specify)

9. Where are you living now? (Please check only one)

- A house An apartment A halfway house or resident program
 A mobile home A shelter, motel or other temporary housing No regular place to live

Other (please specify)

10. In the place where you are now living, do you or does your family? (Please check only one)

- Rent Own Neither (living with someone and not paying rent, shelter, residential program, etc.)

11. Have you ever been pregnant?

- Yes No Not applicable

12. How many children do you have?

- None 2 I do not know
 1 3 or more

13. If you have children of your own, do they live with you most of the time? (Please check only one)

- Yes No Not applicable

14. Would you feel comfortable coming to a clinic that is designed for patients between the ages of 10 and 21? (Please check only one)

- Yes No

15. What hours would you prefer the clinic to be available to you? (Please check all that apply)

- Weekdays
 Saturday
 After School
 Before School
 During School

Other (please specify)