Newport Pediatrics, P.C.
1829 Crowe Lane
Newport, TN 37821

Patient Needs Assessment
KM-11

In order to better understand your child and his/her needs, we'd like to ask you to answer these questions honestly and to the best of your ability. As always, your responses will be kept confidential and used only to provide better healthcare for your child.

Child's Name:______________________________ Child's Date of Birth:_______________

Parent(s)/ Guardian's Name:______________________________ Today's Date:_____________

Does your child have special needs? ___ Yes ___ No
Please describe:______________________________
If yes, does your child require special medical equipment because of his/her condition? ___ Yes ___ No
Please describe:______________________________

Do YOU or someone else in your home have special needs or a medical condition that affects caring for this child?
___ Yes ___ No
If so, who?______________________________
Please describe:______________________________

Do you often need help with transportation to and from doctor's visits and/or to pick up medications from the pharmacy? ___ Yes ___ No

Do you often need help covering the cost of medications and/or copays? ___ Yes ___ No

Have you or someone in your household delayed healthcare due to lack of money and/or insurance? ___ Yes ___ No

Are you homeless or at risk of being homeless? ___ Yes ___ No

Are there times that you are unable to provide food and/or utilities for your family? ___ Yes ___ No

Do you have any other needs or concerns that affect your ability to care for your child? ___ Yes ___ No
Please describe:______________________________