



Member Name: \_\_\_\_\_

Service Location: \_\_\_\_\_

Service Type: \_\_\_\_\_

Date Completed: \_\_\_\_\_ Date Entered: \_\_\_\_\_

Clinician Name: \_\_\_\_\_

**Consumer Health Inventory™**

What is your gender?  What is your date of birth?     
*Male/Female Month Day Year*

**1. How strongly do you agree or disagree with the following statement:**  
 I think that I can deal well with daily problems.      Strongly Agree      Agree      I am Neutral      Disagree      Strongly Disagree  
                       

**2. How confident are you about bouncing back from problems?**  
 Extremely      Quite a Lot      Somewhat      Little      Not at All  
                       

**3. During the past 4 weeks, how often have you made and followed a plan to take care of your physical or mental health?**  
 Always      Often      Sometimes      Rarely      Never  
                       

**4. In general, would you say your health is:**  
 Excellent      Very Good      Good      Fair      Poor  
                       

**5. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?**  
 Yes, limited a lot      Yes, limited a little      No, not limited at all  
 a. Moderate physical activities, such as getting groceries or going to the mailbox.                    
 b. Climbing several flights of stairs.                 

**6. During the past 4 weeks, how much of the time have you had the following problems with your work or other activities because of your physical health?**  
 All of the time      Most of the time      Some of the time      A little of the time      None of the time  
 a. Achieved less than you would like.                                
 b. Were limited in the kind of work or other activities.                             

**7. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other activities because of your mental health?**  
 All of the time      Most of the time      Some of the time      A little of the time      None of the time  
 a. Achieved less than you would like.                                
 b. Were less careful than usual.



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**18.If you use alcohol or drugs (other than those prescribed), how much does it interfere with your life?**

All of the time    Most of the time    Some of the time    A little of the time    None of the time

                                                                                      

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**19.During the past 4 weeks, how much of the time have you heard or seen things that other people don't?**

All of the time    Most of the time    Some of the time    A little of the time    None of the time    Prefer not to answer

                                                                                                            

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**20.During the past 4 weeks, how much of the time have you been anxious or worried?**

All of the time    Most of the time    Some of the time    A little of the time    None of the time

                                                                                      

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**21.How much do you agree or disagree with the following statement:**

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree
I am hopeful that treatment/therapy can help me.	<input type="radio"/>				

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**22.If you are currently in treatment/therapy, please answer the following questions:**

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree
a. I feel my provider is caring and has concern for me.	<input type="radio"/>				
b. I believe that I can better cope with my problems.	<input type="radio"/>				
c. The problem that I came in for treatment/therapy for is better.	<input type="radio"/>				

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**Thank you for taking the Consumer Health Inventory™**

Please click here if you do not want to share the results of this assessment with your provider.

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If you need help, please call 1-800-572-9394. Say that you are trying to take the Magellan CHI™ and we will help you.