



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. I think that I can deal well with daily problems.

Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. I am hopeful that treatment/therapy can help me.

Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. 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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Climbing several flights of stairs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Bending, kneeling, or stooping.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Walking several hundred yards.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give one answer that comes closest to the way you have been feeling. How much of the time:

	All	Most	Some	A little	None
a. Have you been very nervous?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Have you felt calm and peaceful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Have you felt downhearted and depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Have you been happy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The next several questions refer to the past 4 weeks:

5. How much did pain interfere with your daily activities?

Not at all	A little bit	Moderately	Quite a bit	Extremely
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. How much of the time have you heard or seen things that other people don't?

All Most Some A little None Prefer not to answer

7. How much of the time has your health been a problem with such things as seeing friends or family?

All Most Some A little None

8. How often did you awaken during your sleep time and have trouble falling asleep again?

All Most Some A little None

9. How many days have you missed from work, school or other regular activities due to your health?

10. On average, how many days a week do you have an alcoholic drink?

7 6 5 4 3 2 1 0 Prefer not to answer

11. On a typical drinking day, how many drinks do you have?

7 or more 6 5 4 3 2 1 0 Prefer not to answer

12. How often did you use drugs other than those prescribed for you?

Every day Almost every day 3 - 4 days a week 1 - 2 days a week Less than once a week Never Prefer not to answer

13. What statement best describes your use of tobacco products, if any?

Currently use Quit less than 5 years ago Quit over 5 years ago Never used

Thank you for taking the Consumer Health Inventory™

[Click here for your Report](#)

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

CHI™ is a Trademark of QualityMetric Incorporated, All Rights Reserved

If you need [technical support](#) help, please call 1-800-572-9394. Say that you are trying to take the Magellan CHI™ and we will help you.