1. Are you comfortable speaking and understanding English? 
   Yes/Si No

2. If not, do you need a translator?
   Yes/Si No

3. If not English, what language do you speak most often?
   ______________________

4. Are you comfortable with reading materials in English?
   Yes/Si No

5. Do you have (or have you had) any known problems with learning disabilities or emotional barriers?
   Yes/Si No

6. Level of education:
   ______________________________________________________

7. Do you have trouble seeing?
   Yes/Si No

8. If yes, do you have glasses or contacts that help you?
   Yes/Si No

9. Can you read a label?
   Yes/Si No

10. Do you have trouble hearing?
    Yes/Si No

11. Do you have any health needs or preferences that you would like to share with us that would help your care here?
    Yes/ Si No

12. Do you have any social, religious, cultural, considerations that you would like to share with us?
    Yes/ Si No

Reviewer’s Signature ___________________________ Date ___________________________