

## **ARE YOU READY TO MANAGE YOUR OWN HEALTH CARE?**

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|-----|--|-----|----|
| 1.  | I worry about my health.   | Yes | No |
| 2.  | My parents always take care of my health needs.  | Yes | No |
| 3.  | I would like to know more about my illness/disability.                                   | Yes | No |
| 4.  | I would like to be responsible for taking my own medications or doing my own treatments. | Yes | No |
| 5.  | It is easy for me to talk with my doctor.  | Yes | No |
| 6.  | I feel I have little or no control over my illness/disability.                           | Yes | No |
| 7.  | I would like to speak with my doctor alone during visits.                                | Yes | No |
| 8.  | I would like to go to the doctor by myself.  | Yes | No |
| 9.  | Sometimes I get embarrassed if I have to take my medications in front of my friends.     | Yes | No |
| 10. | If I follow my treatments and take my medications, my health is usually good.            | Yes | No |
| 11. | My health needs will affect my future.   | Yes | No |