HEALTH RISK ASSESSMENT

HEALTH | CHOICE GENERATIONS

Please complete the following questions the best that you can. The information will be used to provide resources on how to live a healthy life and prevent disease. Your answers will not affect your benefits.

IMPORTANT: Be sure to complete your Name and Member ID. This information will help us know who you are.

Attn:

Full Name: _____ Date of Birth: _____

Member ID Number: _____ Phone Number: _____

Address: _____

Primary Care Physician: _____ Current Date: _____

How would you rate your overall health over the past 6 months?

☐ Poor ☐ Fair ☐ Good ☐ Very Good

Physical Activity

In the past 7-10 days, have you been physically active?
(Running, walking, stair climbing, stretching, swimming, etc.)

☐ Yes ☐ No

If ***Yes***, How Often?

☐ More than half of the time ☐ Less than half of the time ☐ Half of the time ☐ No physical activity at all

Nutrition

Do you need assistance getting food?

☐ Yes ☐ No If ***yes***, please explain _____

How many of your daily meals have a fruit and/or vegetables?

☐ 0-1 meal a day ☐ 1-2 meals a day ☐ 2-3 meals a day ☐ more than 3 meals a day

How many of your daily meals have fried or fatty foods?

☐ 0-1 meal a day ☐ 1-2 meals a day ☐ 2-3 meals a day ☐ more than 3 meals a day

Chronic medical conditions

What are your major health concerns?
This includes conditions such as Cancer, Arthritis, HTN, Diabetes, Heart Disease, Mental Illness, etc.

Pregnancy

Are you currently pregnant?

☐ Yes ☐ No

Pain

In the past 2 weeks, how much pain have you felt?

Can you rate your pain on a sclae of 0 - 10?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How would you rate your oral health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Smoking Risk

Do you smoke? (NOTE: Smoking includes vaping, cigarettes, cigars, marijuana)

☐ Yes ☐ No

Would you like information on quitting?

☐ Yes ☐ No

Alcohol Use

Do you drink alcohol?

☐ Yes ☐ No

Have you or someone close to you ever felt you should cut down on your drinking?

☐ Yes ☐ No

Other Risks

Do you always wear your seatbelt when you are in a car?

☐ Yes ☐ No

Have you engaged in any high-risk sexual practices in the last year?

☐ Yes ☐ No

Depression

In the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Feeling down, depressed or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Anxiety

In the past two weeks, how often have you been bothered by any of the following problems:

Feeling anxious or on edge?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Not being able to stop or control worrying?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Worrying too much about different things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Trouble relaxing?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Social/Emotional Support

How often do you get the social and emotional support you need?

☐ Always ☐ Sometimes ☐ Never

Other Issues

In the past 2 weeks, how often have you felt tired?

☐ Always ☐ Sometimes ☐ Never

Have you fallen in the last year?

☐ Yes ☐ No

If ***Yes***, how many times? _____ Did you have an injury? ☐ Yes ☐ No

Activities of Daily Living

Do you need assistance with any of the following?

☐ Eating ☐ Bathing ☐ Completely Independent

☐ Dressing ☐ Walking

☐ Grooming ☐ Using the Toilet

IADL's

Do you need assistance with any of the following?

☐ Shopping ☐ Housekeeping ☐ Medications

☐ Food Prep ☐ Laundry ☐ Finances

☐ Telephone ☐ Transportation ☐ Completely Independent