

Health Risk Assessment

Member Name: Member Healthcare ID: Member MBI: DOB: State: Address:	Home Phone: () Cell Phone: () Other: () Assessment DATE: / /
QUESTIONS	ANSWERS
General Information	
Assessment Method:	<input type="checkbox"/> In-person <input type="checkbox"/> Mailed <input type="checkbox"/> Sales/Broker <input type="checkbox"/> Telephonic <input type="checkbox"/> Televisit <input type="checkbox"/> Welcome Kits <input type="checkbox"/> Other: _____
Broker Writing Number:	
Assessment Type:	<input type="checkbox"/> Initial Assessment <input type="checkbox"/> Annual <input type="checkbox"/> Referral <input type="checkbox"/> Change in health status <input type="checkbox"/> Clerical error
Who is completing this form?	<input type="checkbox"/> Member <input type="checkbox"/> Other: _____
Phone for person completing the form	() _____
Are you of Hispanic, Latino, or Spanish origin?	<input type="checkbox"/> No, not Hispanic, Latino or Spanish origin <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, another Hispanic, Latino, or Spanish origin <i>Print origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on:</i> _____ <input type="checkbox"/> I choose not to answer
Please select the racial category or categories which you most closely identify with:	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or another Pacific Islander <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White <input type="checkbox"/> Multiracial: _____ <input type="checkbox"/> Something else: _____ <input type="checkbox"/> I choose not to answer
What language do you prefer we use when speaking to you or sending you materials?	<input type="checkbox"/> Arabic <input type="checkbox"/> Chinese <input type="checkbox"/> Creole <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Mandarin <input type="checkbox"/> Russian

Health Risk Assessment

	<input type="checkbox"/> Somali <input type="checkbox"/> Spanish <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Something else: _____
What is your sexual orientation? (Please choose the option that best describes you.)	<input type="checkbox"/> Lesbian or gay or homosexual <input type="checkbox"/> Straight or heterosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else, please describe: _____ <input type="checkbox"/> I don't know <input type="checkbox"/> I choose not to answer
What is your highest level of school completed?	<input type="checkbox"/> Less than a high school diploma <input type="checkbox"/> High school diploma/ GED <input type="checkbox"/> Vocational / Trade school <input type="checkbox"/> Some college <input type="checkbox"/> College degree (associates or bachelor's) <input type="checkbox"/> Graduate degree <input type="checkbox"/> I choose not to answer
What is your living situation?	<input type="checkbox"/> Live in a home that I own <input type="checkbox"/> Live in a home/ apartment that I rent <input type="checkbox"/> Live with family member <input type="checkbox"/> Live in a shelter <input type="checkbox"/> Live in foster care <input type="checkbox"/> Live in a group home <input type="checkbox"/> Live in an assisted living facility <input type="checkbox"/> Nursing home <input type="checkbox"/> Homeless/ unsheltered <input type="checkbox"/> Something else: _____ <input type="checkbox"/> I choose not to answer
Do you have any preferences or considerations we should be aware of? Please select all that apply.	<input type="checkbox"/> Cultural preferences: _____ <input type="checkbox"/> Religion/ Spiritual needs or preferences: _____ <input type="checkbox"/> Hearing difficulty: _____ <input type="checkbox"/> Vision problems: _____ <input type="checkbox"/> None <input type="checkbox"/> Something else: _____
Have you been diagnosed with or are currently being treated for any of the following behavioral health conditions? Please select all that apply.	<input type="checkbox"/> I have never been diagnosed or treated for any behavioral health conditions <input type="checkbox"/> ADHD (attention deficit hyperactivity disorder) <input type="checkbox"/> Anxiety <input type="checkbox"/> Autism <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Depression <input type="checkbox"/> Psychotic disorder (Schizophrenia) <input type="checkbox"/> Substance use disorder <input type="checkbox"/> Other: _____
Do you use illegal substances or prescription medications not prescribed for you? (such as cocaine, heroin, opioids)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I choose not to answer
In the past year, have you consumed alcohol daily, needed to drink in the morning, or have people annoyed you by criticizing your drinking?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I choose not to answer

Health Risk Assessment

Are you interested in assistance from one of our healthy lifestyles programs for weight management or tobacco cessation?	<input type="checkbox"/> Tobacco Cessation <input type="checkbox"/> Weight Management <input type="checkbox"/> I am not interested <input type="checkbox"/> I choose not to answer
--	---

General Health	
Do you have a main health concern right now?	<input type="checkbox"/> Yes: _____ <input type="checkbox"/> No <input type="checkbox"/> I choose not to answer
Have you been diagnosed with or are you currently being treated for any of the following health conditions? Please select all that apply.	<input type="checkbox"/> I have never been diagnosed or treated for any health conditions <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer (actively being treated) <input type="checkbox"/> Cognitive (memory concerns, such as dementia) and/or development limitations <input type="checkbox"/> COPD (chronic obstructive pulmonary disease) <input type="checkbox"/> Diabetes <input type="checkbox"/> Kidney failure/dialysis <input type="checkbox"/> Heart failure <input type="checkbox"/> Stroke <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Liver disease, such as cirrhosis or ascites <input type="checkbox"/> High blood pressure <input type="checkbox"/> Neurologic disorder (such as epilepsy, multiple sclerosis) <input type="checkbox"/> Blood disorders (this covers those with anemia, sickle cell or clotting deficiencies) <input type="checkbox"/> Other: _____
Do you worry about your memory or have you been told by friends or family that they are worried about your memory?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I choose not to answer
Do you have pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I choose not to answer
If yes, where is your pain located?	_____
Rate your pain on a 1-10 scale(10 worst)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> I choose not to answer
In the past 6 months, how often have you visited the emergency room or stayed overnight in the hospital?	<input type="checkbox"/> One time or not at all <input type="checkbox"/> 2 to 5 times <input type="checkbox"/> more than 6 times <input type="checkbox"/> I choose not to answer
Are you taking your medications as prescribed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not prescribed medications <input type="checkbox"/> I choose not to answer
Have you fallen in the last 6 months that resulted in medical care?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
If yes, please describe:	_____

Health Risk Assessment

Are you currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> I choose not to answer <input type="checkbox"/> N/A
-----------------------------	---

Service Coordination	
Are you currently receiving any long-term services and supports, such as personal attendant services, day activity services, or emergency services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you need assistance for yourself or your child with any of the following?	<input type="checkbox"/> I choose not to answer <input type="checkbox"/> Bathing/ Showering <input type="checkbox"/> Hygiene <input type="checkbox"/> Dressing <input type="checkbox"/> Walking/ Mobility <input type="checkbox"/> Toileting <input type="checkbox"/> Eating <input type="checkbox"/> Grocery shopping <input type="checkbox"/> Meal preparation <input type="checkbox"/> Housework/ cleaning <input type="checkbox"/> Managing finances <input type="checkbox"/> Climbing stairs

Social Determinants of Health	
What is your housing situation today?	<input type="checkbox"/> I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) <input type="checkbox"/> I have housing today, but I am worried about losing housing in the future <input type="checkbox"/> I have housing <input type="checkbox"/> I choose not to answer
In the past year, have you or any family members you live with been unable to get food when it was really needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I choose not to answer
Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.	<input type="checkbox"/> Yes, it has kept me from medical appointments or getting medications <input type="checkbox"/> Yes, it has kept me from non-medical meetings, appointments, work, or getting things I need <input type="checkbox"/> No <input type="checkbox"/> I choose not to answer
Do you feel physically and emotionally safe where you currently live?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> I choose not to answer
In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.	<input type="checkbox"/> Clothing <input type="checkbox"/> Utilities <input type="checkbox"/> Child Care <input type="checkbox"/> Medicine or any healthcare (medical, dental, mental health, vision)

Health Risk Assessment

	<input type="checkbox"/> Phone <input type="checkbox"/> Money <input type="checkbox"/> Training/ Employment <input type="checkbox"/> Other <input type="checkbox"/> I choose not to answer
--	--

Future Medical Care	
Do you have a living will or an advanced directive in place (a document of your medical care wishes if you are unable to provide them)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you want information on living wills and advanced directives?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Behavioral Health	
Over the last 2 weeks, how often have you had little interest or pleasure in doing things?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day <input type="checkbox"/> I choose not to answer
Over the last 2 weeks, how often have you been feeling down, depressed, or hopeless?	<input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day <input type="checkbox"/> I choose not to answer
In the past year, have you thought about harming yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I choose not to answer
Do you currently have any thoughts about harming yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I choose not to answer