Health Risk Assessment (HRA)

Name: _____ Date:_____

Date of Birth: _____ Preferred language:_____

Form completed by: □ Self □ Friend/family □ Office staff □ Other _____

How do you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Are there any changes in your medical history since last year? ☐ Yes ☐ No (if yes, list)

_____

On how many days during the week do you…? (Circle the appropriate answer below)

1)	Do physical activity (e.g. walking, sports, etc.) for at least 30 minutes?	0	1 - 2	3 - 4	≥5
2)	Include strength exercises (weights or bands) in your physical activity routine?	0	1 - 2	3 - 4	≥5
3)	Eat 5 or more servings of fruits and vegetables (one serving equals ½ cup)?	0	1 - 2	3 - 4	≥5
4)	Eat 5 or more servings of grains (one serving equals one slice of bread, ½ cup of cereal, etc.)?	0	1 - 2	3 - 4	≥5
5)	Eat 2 or more servings of dairy products (milk, yogurt or cheese)?	0	1 - 2	3 - 4	≥5
6)	Eat fast food?	0	1 - 2	3 - 4	≥5
7)	Cut the size of your meals or skip meals because you don't have enough food (not enough money or enough help to shop or cook)?	0	1 - 2	3 - 4	≥5
8)	Have more than one drink of alcohol (beer, liquor, wine) per day?	0	1 - 2	3 - 4	≥5
9)	Get at least 7 hours of sleep?	0	1 - 2	3 - 4	≥5
10)	Use tobacco or nicotine products (cigarettes, e-cigarettes, smokeless tobacco, cigars, or pipes) or are close to others who do?	0	1 - 2	3 - 4	≥5
11)	Leave your home to run errands, go to work, go to meetings, classes, church, social functions, etc. (not counting doctor's visits)?	0	1 - 2	3 - 4	≥5
12)	Have physical pain that affects your activities?	0	1 - 2	3 - 4	≥5

13) Do you have mouth or tooth problems that make it difficult to eat?	☐ Yes	☐ No
14) Do you have enough money to pay for your medicines, medical supplies, and medical care?	☐ Yes	☐ No
15) About how many times **in the last month** have you…		
...missed taking your medicines?	_____ times	
...taken your medicines differently than prescribed by your doctor?	_____ times	
...taken any over-the-counter medicines (non-prescription medicines, supplements or herbal medicines)?	_____ times	
16) Do you drive?	☐ Yes	☐ No
If no, are you able to get where you need to go?	☐ Yes	☐ No
17) Are you sexually active? (if yes, # partners in last 12 months ____)	☐ Yes	☐ No
18) Do you have problems hearing or seeing? (if yes, circle which one)	☐ Yes	☐ No
19) In the **past 12 months**, have you had any problem with balance or walking, or have you had any falls? If yes to falls, how many falls? _____	☐ Yes	☐ No
Are you concerned about falling?	☐ Yes	☐ No
20) Are you or your family concerned about your memory?	☐ Yes	☐ No
21) In the **past 6 months**, have you had a problem with leakage of urine?	☐ Yes	☐ No
22) In the **past month**, have you needed help managing your finances?	☐ Yes	☐ No
23) Do you think anybody is taking or using your money without your permission?	☐ Yes	☐ No
24) In the **past 7 days**, have you needed help from others…		
….to eat, bathe, get dressed or use the toilet?	☐ Yes	☐ No
….to do laundry, cooking, housekeeping or shopping?	☐ Yes	☐ No
….to take your medicines?	☐ Yes	☐ No
25) Do you or your caregiver have enough help/support for caregiving duties? (skip if you do not give or receive care)	☐ Yes	☐ No
26) Are you often lonely?	☐ Yes	☐ No
27) Do you have family and friends who care about you and you can count on for help when you need something or have a problem?	☐ Yes	☐ No
28) Is anybody hurting (hitting or yelling) or not taking care of you?	☐ Yes	☐ No
29) Do you have an Advance Directive or Living Will?	☐ Yes	☐ No

Over the <u>last two weeks</u>, how often have you been bothered by the following problems?

	Not at all	Several Days	> Half of the Days	Nearly Every Day
33) Anxiety or stress about your health, money, family, friends or work?	☐	☐	☐	☐
34) Little interest or pleasure in doing things?	☐	☐	☐	☐
35) Feeling down, depressed or hopeless?	☐	☐	☐	☐

List of Medicines and Supplements You Take

Name of medicine/supplement	Dose and how often taken
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	

Other healthcare providers you see (and their specialty)

1.	5.
2.	6.
3.	7.
4.	8.

Medical supplies you receive (e.g. oxygen) and who supplies it:

For Office Use Only

Height: _____ Weight: _____ BMI: _____ BP: ____/____ P:_____

PHQ -2 Score: ____ PHQ-9 Score (if indicated):_____

Other mental health screen, if indicated: (name/score) _____

Mini-Cog Score: _____ Other cognitive screen, if indicated: (name/score) _____

Timed Up and Go: _____

☐ Home safety checklist reviewed

☐ Personal Preventive Plan completed and reviewed with patient

Information/education provided:

☐ Exercise ☐ Healthy Eating ☐ Dietary supplements ☐ Food Banks/Meals on Wheels
☐ Fall prevention ☐ Pain ☐ Depression ☐ Sleep
☐ Cognitive impairment ☐ Medication use ☐ Transportation resources
☐ Caregiver resources ☐ Abuse prevention ☐ Scam prevention
☐ Veteran's benefits ☐ Health Insurance Counseling Advocacy Program(HICAP)
☐ Speech/hearing center ☐ Braille Institute ☐ Advance Directive/Living Will
☐ Adult Day Care ☐ Alzheimer's Association ☐ Long Term Support Services (LTSS)
☐ Other _____

Referrals made/provided:

☐ Dental ☐ Optometry ☐ PT evaluation ☐ Pain management ☐ Dementia evaluation
☐ Psychiatry/Counseling/behavioral health ☐ Dietician/nutrition counseling
☐ Bone Mineral Density ☐ Colonoscopy ☐ Mammogram ☐ Pap smear
☐ Alcohol reduction ☐ Tobacco cessation ☐ Chronic Disease Self-Management Class
☐ Case management ☐ Driving evaluation ☐ Friendly visitor program
☐ Other _____