Name_____ Date_____ Provider_____

Health Risk Assessment Form

In general, my overall health is: ☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

List any hospitalizations, major illness, or visits to the emergency room since *LAST YEAR or LAST VISIT*

Date	Reason	Location

Medical History

Personal and Family Medical History				☐ **No changes since last year/visit**		
	Me	Father	Mother	Siblings	Children	Specify Disease
Heart Disease						
High Blood Pressure						
High Cholesterol						
Stoke/ Cerebral Vascular Disease						
Kidney Disease						
Cancer						
Diabetes						
Aortic Aneurysm						
Amputation						

Past Surgeries (or new since last visit)	Date	Past Surgeries	Date

Names of All Providers / Specialists You See:

Doctor's Name	Specialty	Doctor's Name	Specialty

List of Medical Equipment/Service Providers

Provider		
Oxygen/CPAP:	Home Health:	Other:

Changes in medications or allergies since last year or last visit ☐ No changes since last year/visit

Medication	Dose	Reason for Taking

Allergies	Reaction	Allergies	Reaction

Are you having trouble taking your medications as prescribed? Yes ☐ No ☐

Accident Prevention:

Do you wear seatbelts in the car? ☐ Yes ☐ No

Do you have smoke detectors at home? ☐ Yes ☐ No

Do you have carbon monoxide detectors? ☐ Yes ☐ No

Do you have firearm(s) at home? ☐ Yes ☐ No If yes, locked up? ☐ Yes ☐ No

Activities of Daily Living

Do you require assistance with any of the following activities?

Using the telephone	☐ Yes ☐ No	Eating	☐ Yes ☐ No
Shopping	☐ Yes ☐ No	Getting from bed to chair	☐ Yes ☐ No
Meal preparation	☐ Yes ☐ No	Dressing	☐ Yes ☐ No
Housekeeping	☐ Yes ☐ No	Bathing	☐ Yes ☐ No
Laundry	☐ Yes ☐ No	Walking	☐ Yes ☐ No
Driving/taking taxi or bus	☐ Yes ☐ No	Getting on/off toilet	☐ Yes ☐ No
Taking medications	☐ Yes ☐ No	**Urinary/Bowel Incontinence**	☐ Yes ☐ No
Handling finances	☐ Yes ☐ No		

Would you like to speak to your provider about bladder control or trouble with urinary leakage? ☐ Yes ☐ No

I have someone available to help if needed (for a sick day) ☐ Yes, any time ☐ Yes, sometimes ☐ Not really

Personal concern about your memory - or family mentions concern ☐ Yes ☐ No

Diet: ☐ balanced ☐ vegetarian ☐ diabetic ☐ low salt ☐ low fat ☐ low carb ☐ other: _____

Do you exercise every day? ☐ No ☐ Yes If not daily, how often? _____

Have you had any falls in the past year? ☐ No ☐ Yes If yes, any injuries: _____

I use a: ☐ cane ☐ prosthetic ☐ walker ☐ wheelchair/scooter ☐ other: _____

In the last two weeks check (√) how often you have been bothered by the following:	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				

If you checked *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Do you drink alcohol? ☐ Yes ☐ No ☐ I No longer drink alcohol
How many times in the last year have you had more than 5 drinks (male)/4 drinks (female) in one day? ____
☐ **I'm interested in talking more about my alcohol use**

Have you ever smoked or chewed tobacco or smoked marijuana? ☐ No ☐ Yes ☐ Current: _____ per day
☐ **I'm interested in help to stop using** _____

Do you use illicit drugs? ☐ No ☐ Yes ☐ **I'm interested in help to stop using** _____

Do you ever take prescription drugs for non-medical reasons? ☐ No ☐ Yes
If yes, how often? ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily
☐ **I'm interested in talking more about prescription drug use**

HEALTH SCREENINGS:

Do you have trouble with speech? ☐ Yes ☐ No

Do you have trouble seeing? ☐ Yes ☐ No Do you wear glasses or contacts? ☐ Yes ☐ No

Do you have trouble hearing? ☐ Yes ☐ No Do you wear a hearing aid? ☐ Yes ☐ No Exam Date: _____

I have a: ☐ Living will ☐ Medical Order for Life Sustaining Treatment (MOST)
☐ Medical Power of Attorney ☐ Other: _____
☐ **I'm interested in learning more about documenting my wishes for end-of-life decision-making**

I'd like to talk with a Care Coordinator about _____.
A Care Coordinator can assist with managing chronic diseases like diabetes, heart failure and COPD. They can help find options for: reducing cost of medications, transportation, long-term care planning, caregiver support, end of life decision-making, resources for mental health or substance abuse.

PROVIDER SIGNATURE (reviewed)_____
☐ No cognitive issues detected ☐ Cognition screen prompts Mini-Cog or SLUM, results and plan in visit note.

Referral to Care Coordinator completed _____ (initials)

Personalized Preventive Plan of Services (PPPS) completed and given to patient: _____ (initials)

Name_____ Date_____ Provider_____

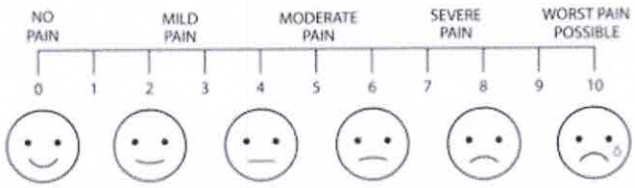
Pain Assessment - ONLY IF USING OPIODS

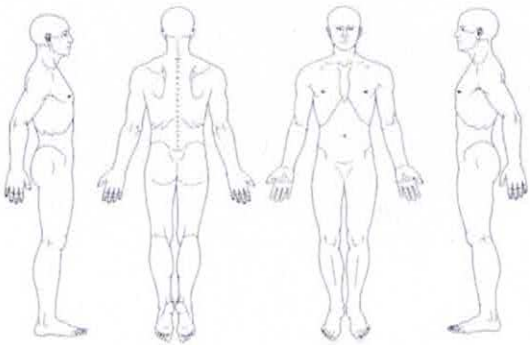
Is the pain constant? ☐ Yes ☐ No Onset, duration, and variation: _____

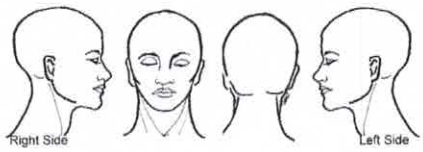
Type of pain: ☐ Ache ☐ Deep ☐ Sharp ☐ Hot ☐ Cold ☐ Sensitive skin ☐ Other: _____

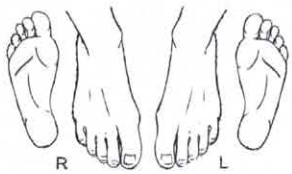
Intensity: on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain you can imagine, how is your pain right now?

Mark location of pain on diagrams below:









What relieves the pain? _____

I'm interested in other options to manage my pain: ☐ Yes ☐ No

Do you see a specialist to manage your pain? ☐ Yes ☐ No Specialist: _____

Is your pain medication for: ☐Post-surgery (short term) or ☐ Chronic pain

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal Drugs	2	3
Rx Drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal Drugs	4	4
Rx Drugs	5	5
Age between 16-45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		