



Health Risk Assessment Survey

Thank you for choosing Clear Spring Health as your health care provider. We are your partners in working to get healthy and stay healthy. This brief survey is an important tool for us to learn more about you and any health care needs you may have.

The information you provide in this form is personal health information protected by federal and state law and will be kept confidential. It **CANNOT** be used to deny health care coverage.

If you need assistance with completing or returning this form, contact Care Management Department at 1-866-938-3720 (TTY: 711).

*Member Name:		*Physical Address:	
*Phone Number:		*Mailing Address:	
*Member ID or MBI:		Member email:	
DEMOGRAPHICS			
*Date of Birth:		*Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
*Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:			
*Are Translation Services Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
*Are you of Hispanic, Latino, or of Spanish origin? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Prefer not to Answer			
*Who is answering these assessment questions? <input type="checkbox"/> Member <input type="checkbox"/> Caregiver <input type="checkbox"/> Spouse If Other, provide information below Name: Phone:		*What is your primary race? <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Two or More Races <input type="checkbox"/> Unknown <input type="checkbox"/> Some Other Race <input type="checkbox"/> Prefer not to Answer	
How is this Health Risk Assessment being completed? <input type="checkbox"/> Phone Interview <input type="checkbox"/> Written <input type="checkbox"/> Online/Web <input type="checkbox"/> In-Person			
*Height (Feet/Inches):		*Weight:	*Name of Primary Care Physician:
Are you a veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No		If you a veteran, do you get health care at the VA? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A If yes, please provide the name of the VA clinic or the address:	
What is your marital status? <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner/Common Law Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		What is your current combined household income? <input type="checkbox"/> Less than \$25,000 <input type="checkbox"/> Between \$25,000 and \$50,000 <input type="checkbox"/> Between \$50,000 and \$100,000 <input type="checkbox"/> More than \$100,000 <input type="checkbox"/> Prefer not to answer	
Are you registered with the Special Needs Registry? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have any of the following? <input type="checkbox"/> Living Will <input type="checkbox"/> Power of Attorney (POA) <input type="checkbox"/> Guardian/Caregiver <input type="checkbox"/> Healthcare Proxy <input type="checkbox"/> Advanced Directive <input type="checkbox"/> None of the above		If Guardian/Caregiver was selected, please provide their information below: Name: Phone:	
Do you have any family traditions or religious/spiritual beliefs related to illness, death, and dying that you would like for us to know about?			

SOCIAL/BEHAVIORAL RISK	
<p>*Do you smoke or use Tobacco products (like cigarettes, pipe, or smokeless tobacco)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>*How many alcoholic drinks (like wine, beer, or mixed drinks) do you have in a normal week? <input type="checkbox"/> 0 drinks <input type="checkbox"/> 1-6 drinks <input type="checkbox"/> 7-13 drinks <input type="checkbox"/> 14 or more drinks</p>
<p>*Do you use recreational drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Have you been to the dentist in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not remember</p>	<p>Do you follow safe sexual practices? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable</p>
<p>Do you always fasten your seat belt when you are in the car? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>* Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? ¹ (Check all that apply) <input type="checkbox"/> Yes, it has kept me from medical appointments or from getting my medications <input type="checkbox"/> Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need. <input type="checkbox"/> No <input type="checkbox"/> I choose not to answer this question</p>
<p>Have you had an eye exam in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household? ² <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently Homeless</p>	<p>Think about the place you live. Do you have problems with any of the following? (Check all that apply) ³ <input type="checkbox"/> Bug infestation <input type="checkbox"/> Mold <input type="checkbox"/> Lead paint or pipes <input type="checkbox"/> Inadequate heat <input type="checkbox"/> Oven or stove not working <input type="checkbox"/> No or not working smoke detectors <input type="checkbox"/> Water leaks <input type="checkbox"/> Loose rugs <input type="checkbox"/> No or not working Carbon Monoxide detector <input type="checkbox"/> No good lighting in walkways <input type="checkbox"/> No solid handrails on stairs <input type="checkbox"/> Non-slip flooring in tub or shower <input type="checkbox"/> None of the above</p>
<p>Within the past 12 months, you worried that your food would run out before you got money to buy more? ⁴ <input type="checkbox"/> Often true <input type="checkbox"/> Sometimes true <input type="checkbox"/> Never true</p>	<p>Within the past 12 months, the food you bought just didn't last and you didn't have money to get more? ⁴ <input type="checkbox"/> Often true <input type="checkbox"/> Sometimes true <input type="checkbox"/> Never true</p>
<p>Does anyone, including friends and family, physically, emotionally, or financially try to hurt you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
MENTAL HEALTH	
<p>*Over the past 2 weeks, how often have you felt down, depressed, or hopeless? <input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More days than not <input type="checkbox"/> Nearly every day</p>	<p>Over the past 2 weeks, how often have you felt little interest or pleasure in doing things? <input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More days than not <input type="checkbox"/> Nearly every day</p>
<p>*During the last 6 months, have you experienced any of the following? <input type="checkbox"/> Stress <input type="checkbox"/> Nervousness/Anxiety <input type="checkbox"/> Loneliness <input type="checkbox"/> Fatigue <input type="checkbox"/> None apply <input type="checkbox"/> Personal loss, disability, divorce, or death of someone close to you</p>	

GENERAL HEALTH	
*Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Please list your allergies:
*In general, would you say your health is: <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
*Do you have any hearing problems for which you need help such as a hearing aid or TTY? <input type="checkbox"/> Yes <input type="checkbox"/> No	*Do you have a problem with seeing or your vision which requires glasses/contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No
*Do you have any difficulty walking which requires the use of a cane, walker, or wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am bedbound	*Have you suffered a fall during the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
How many days a week do you normally get 20 minutes or more of exercise/activity? <input type="checkbox"/> 0-2 days <input type="checkbox"/> 3-5 days <input type="checkbox"/> 6-7 days	*Do you currently suffer from any pain? (Chronic or acute) <input type="checkbox"/> Yes <input type="checkbox"/> No
From a scale of 1 through 5, please indicate your current pain level (5 being the worst pain). <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5	
Over the past 7 days, how many servings of fruits or vegetables did you eat each day? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 or more servings	Are you on any special diet for medical or personal reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No
*If you are on a special diet, please select all that apply: <input type="checkbox"/> Low Fat/Cholesterol <input type="checkbox"/> Diabetic <input type="checkbox"/> Low Sodium <input type="checkbox"/> Vegetarian/Vegan <input type="checkbox"/> Puree <input type="checkbox"/> Kosher <input type="checkbox"/> Renal <input type="checkbox"/> Gluten Free <input type="checkbox"/> Other: _____ <input type="checkbox"/> Not applicable	
Do you need any help from others to perform the following everyday activities? <input type="checkbox"/> Bathing <input type="checkbox"/> Brushing your hair/teeth <input type="checkbox"/> Getting in and out of a chair or a bed <input type="checkbox"/> Dressing: this includes taking clothes off and putting clothes on, reaching above your head, and using buttons and zippers <input type="checkbox"/> Eating: this includes cutting your food and opening any containers with food inside <input type="checkbox"/> Using the bathroom: this includes pulling clothes up and down, and cleaning yourself <input type="checkbox"/> Walking: walking more than 10 feet without using a walker, cane, or holding onto furniture <input type="checkbox"/> None of these apply to me	
*Do you need help doing any of the following activities? <input type="checkbox"/> Using the phone <input type="checkbox"/> Transportation <input type="checkbox"/> Housework: this includes sweeping, mopping, changing sheets, and taking out the trash <input type="checkbox"/> Laundry: this includes washing, drying, ironing, folding clothing, and house items <input type="checkbox"/> Making your meals: this includes cleaning food, cutting foods, and cooking <input type="checkbox"/> Shopping: this includes getting groceries and other items needed for your home <input type="checkbox"/> Medication management: this includes taking your medications on time, getting refills <input type="checkbox"/> Money management: This includes paying bills on time, budgeting for groceries or bills <input type="checkbox"/> None of these apply to me	
*Have you visited your primary care physician in the last 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	*How many times have you been admitted to the hospital in the last 12 months? <input type="checkbox"/> 0 times <input type="checkbox"/> 1-2 times <input type="checkbox"/> 3 or more times

*What is your main health concern right now? Please tell us below.	
SURVEY COMPLETION CONFIRMATION	
Please provide the details of the person that filled this Health Risk Assessment below:	
*Date:	*Full Name:
*Agent NPN (if applicable):	Staff Title (if applicable):

SUBMIT

References

1. This question originally comes from the national PRAPARE social determinants of health assessment protocol, developed and owned by the National Association of Community Health Centers (NACHC), in partnership with the Association of Asian Pacific Community Health Organization (AAPCHO), the Oregon Primary Care Association (OPCA), and the Institute for Alternative Futures (IAF). For more information, visit www.nachc.org/prapare.
2. https://www.va.gov/HOMELESS/Universal_Screener_to_Identify_Veterans_Experiencing_Housing_Instability_2014.pdf
3. Nuruzzaman N, Broadwin M, Kourouma K, Olson DP. Making the social determinants of health a routine part of medical Care. J Health Care Poor Underserved. 2015;26(2):321-327.
4. Hager ER, Quigg AM, Black MM, et al. Development and validity of a 2-item screen to identify families at risk for food insecurity. Pediatrics. 2010;126(1):e26-e32.