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:** ☐ Female ☐ Male

***Primary Language:** ☐ English ☐ Spanish ☐ Other:

***Are Translation Services Needed?** ☐ Yes ☐ No

***Are you of Hispanic, Latino, or of Spanish origin?** ☐ Yes ☐ No ☐ Unknown ☐ Prefer not to Answer

***Who is answering these assessment questions?** ☐ Member ☐ Caregiver ☐ Spouse If Other, provide information below Name: Phone:	***What is your primary race?** ☐ Black/African American ☐ White ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander ☐ Two or More Races ☐ Unknown ☐ Some Other Race ☐ Prefer not to Answer

How is this Health Risk Assessment being completed?
☐ Phone Interview ☐ Written ☐ Online/Web ☐ In-Person

***Height (Feet/Inches):**	***Weight:**	***Name of Primary Care Physician:**

Are you a veteran? ☐ Yes ☐ No	**If you a veteran, do you get health care at the VA?** ☐ Yes ☐ No ☐ N/A If yes, please provide the name of the VA clinic or the address:

What is your marital status? ☐ Single ☐ Separated ☐ Married ☐ Domestic Partner/Common Law Partner ☐ Divorced ☐ Widowed **Are you registered with the Special Needs Registry?** ☐ Yes ☐ No	**What is your current combined household income?** ☐ Less than $25,000 ☐ Between $25,000 and $50,000 ☐ Between $50,000 and $100,000 ☐ More than $100,000 ☐ Prefer not to answer
Do you have any of the following? ☐ Living Will ☐ Power of Attorney (POA) ☐ Guardian/Caregiver ☐ Healthcare Proxy ☐ Advanced Directive ☐ 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?

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SOCIAL/BEHAVIORAL RISK

***Do you smoke or use Tobacco products (like cigarettes, pipe, or smokeless tobacco)?**
☐ Yes ☐ No

***Do you use recreational drugs?**
☐ Yes ☐ No

***How many alcoholic drinks (like wine, beer, or mixed drinks) do you have in a normal week?**
☐ 0 drinks ☐ 1-6 drinks ☐ 7-13 drinks
☐ 14 or more drinks

Have you been to the dentist in the last year?
☐ Yes ☐ No ☐ Do not remember

Do you follow safe sexual practices?
☐ Yes ☐ No ☐ Not applicable

Do you always fasten your seat belt when you are in the car?
☐ Yes ☐ No

Have you had an eye exam in the last year?
☐ Yes ☐ No

*** Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? [1] (Check all that apply)**
☐ Yes, it has kept me from medical appointments or from getting my medications
☐ Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need.
☐ No
☐ I choose not to answer this question

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]
☐ Yes ☐ No ☐ Currently Homeless

Think about the place you live. Do you have problems with any of the following? (Check all that apply) [3]
☐ Bug infestation ☐ Mold ☐ Lead paint or pipes
☐ Inadequate heat ☐ Oven or stove not working
☐ No or not working smoke detectors
☐ Water leaks ☐ Loose rugs
☐ No or not working Carbon Monoxide detector
☐ No good lighting in walkways
☐ No solid handrails on stairs
☐ Non-slip flooring in tub or shower
☐ None of the above

Within the past 12 months, you worried that your food would run out before you got money to buy more? [4]
☐ Often true
☐ Sometimes true
☐ Never true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more? [4]
☐ Often true
☐ Sometimes true
☐ Never true

Does anyone, including friends and family, physically, emotionally, or financially try to hurt you?
☐ Yes ☐ No

MENTAL HEALTH

***Over the past 2 weeks, how often have you felt down, depressed, or hopeless?**
☐ Not at all ☐ Several days
☐ More days than not ☐ Nearly every day

Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?
☐ Not at all ☐ Several days
☐ More days than no ☐ Nearly every day

***During the last 6 months, have you experienced any of the following?**
☐ Stress ☐ Nervousness/Anxiety ☐ Loneliness ☐ Fatigue ☐ None apply
☐ Personal loss, disability, divorce, or death of someone close to you

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

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PREVENTATIVE CARE

***Have you had any of the following preventative screenings?**

☐ Pap Smear (Cervical Cancer) in the last 12 months (for females) ☐ N/A
☐ Mammogram in the past 24 months (for females aged 45 and above) ☐ N/A
☐ Bone Density and/or Osteoporosis Screening (for females aged 65-85) ☐ N/A
☐ Prostate Exam (for males aged 50 and above) ☐ N/A
☐ Colorectal Cancer Screening (for all ages 45 and above) ☐ N/A
☐ I haven't had any preventative screenings

***Please select the types of Colorectal Cancer Screening you've had:**

☐ FOBT (Occult Blood in the Stool)
☐ Flexible Sigmoidoscopy
☐ Colonoscopy
☐ Cologuard
☐ CT- Colonography
☐ None

Date of last Colorectal Cancer Screening:

____

Results:

☐ Normal
☐ Abnormal

***Have you had any of the following preventative vaccines?**

☐ Flu Vaccine (in last year)
☐ Pneumonia Vaccine
☐ None of the above

HEALTH CONDITIONS

***Do you currently or have you ever been told that you have any of the following conditions?**

☐ Asthma ☐ Arthritis (Type): ____
☐ Cancer (Type) ____ ☐ Diabetes Type 1
☐ Diabetes Type 2 ☐ Heart Attack (Age?): _______ ☐ Heart Failure ☐ Heart Rhythm Issues
☐ Vascular Disease (Type): ____ ☐ High Blood Pressure
☐ High Cholesterol ☐ Kidney Disease ☐ COPD ☐ Other Lung Issues (Emphysema, Fibrosis)
☐ Mental Health (Anxiety, Depression, Bipolar, Schizophrenia, Post Traumatic Stress Disorder or PTSD)
☐ Neurological (Alzheimer's, Dementia, Parkinson's, Convulsions, Multiple Sclerosis)
☐ Currently Pregnant ☐ Stroke
☐ Other:

***How many prescription drugs do you take?**

☐ None ☐ 1-5 drugs ☐ 6 or more drugs

Please name your current prescriptions and over-the-counter medications (Include medication name, medication dosage, and how often you take it. Include an additional page if needed):

Medication Name	Dosage	Frequency

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***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 OrWganization (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.