Health Risk Assessment

Demographics

Name:_____DOB:_____Date:_____

Gender: □ Male □ Female Height_____ Weight_____

Information provided by: □ Patient □ Caregiver □ Family Member □ Other: _____

Marital status? □ Single □ Married □ Separated □ Divorced □ Widowed □ Other _____

Living Situation? □ Alone □ with Family/Partner □ with Friends/Roommates □ Homeless □Board & Care

□ Group home □ other_____

Hospitalizations past 2 year (if any)? Please describe reason for hospitalization and date of occurrence:

_____

Emergency room visits past 2 years (if any)? Please describe reason for emergency room visit and date of occurrence:

_____

Physical Activity

In the past 7 days, how many days did you exercise?_____days

On days when you exercised, for how long did you exercise (in minutes)?_____minutes per day ☐ Does not apply

Tobacco

In the last 30 days, have you used tobacco? Smoked: ☐ Yes ☐ No

Used a smokeless tobacco product: ☐ Yes ☐ No

If Yes to either, Would you be interested in quitting tobacco use within the next month? ☐ Yes ☐ No

Alcohol Use

In the past 7 days, on how many days did you drink alcohol?_____days

On days when you drank alcohol, how often did you have_____(5 or more for men, 4 or more for women and those men and women 65 years old or over) alcoholic drinks on one occasion?

☐ Never ☐ 2–3 times during the week

☐ Once during the week ☐ More than 3 times during the week

Do you ever drive after drinking, or ride with a driver who has been drinking? ☐ Yes ☐ No

Depression

In the past 2 weeks, how often have you felt down, depressed, or hopeless?

☐ Almost all of the time ☐ Some of the time

☐ Most of the time ☐ Almost never

In the past 2 weeks, how often have you felt little interest or pleasure in doing things?

☐ Almost all of the time ☐ Some of the time

☐ Most of the time ☐ Almost never

Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?

☐ Yes ☐ No

How often do you get the social and emotional support you need?

☐ Always ☐ Rarely

☐ Usually ☐ Never

☐ Sometimes

Pain

In the past 7 days, how much pain have you felt?

☐ None ☐ A lot

☐ Some

General Health

In general, would you say your health is

☐ Excellent ☐ Fair

☐ Very good ☐ Poor

☐ Good

How would you describe the condition of your mouth and teeth—including false teeth or dentures?

☐ Excellent ☐ Fair

☐ Very good ☐ Poor

☐ Good

Activities of Daily Living/ Safety

In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet? ☐ Yes ☐ No

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In the past 7 days, did you need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking your own medications? ☐ Yes ☐ No

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

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Does your home have the following?

Smoke Detectors, or Sprinklers ☐ Yes ☐ No Fire Extinguisher ☐ Yes ☐ No Fire place ☐ Yes ☐ No

Pool or hot tub ☐ Yes ☐ No

Have you fallen in the past year? □ yes □ no Are you afraid of falling? ☐Yes ☐ No

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Do you use any assistive devices to move around (Check all that apply)

☐ Person (Family, caregiver) ☐Wheelchair ☐ Cane ☐ Walker ☐ No I do not use anything

Sleep

Each night, how many hours of sleep do you usually get?_____hours

Do you snore or has anyone told you that you snore? ☐ Yes ☐ No

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In the past 7 days, how often have you felt sleepy during the daytime?

☐Always ☐Usually ☐ Sometimes ☐ Rarely ☐ Never