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

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

1)	Engage in physical activity (e.g. walking, cycling, etc.) for at least 20 to 30 minutes?	0	1 - 2	3 - 4	≥5
2)	Include strength exercises (weights or resistance 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 visit your dentist for regular check-ups at least every six months if you have natural teeth, or once a year if you have full dentures?	☐ Yes ☐ No
14)	Do you have enough money to pay for the medications, medical supplies, and medical visits that you need?	☐ Yes ☐ No
15)	About how many times **in the last month** have you missed taking your medications?	_____ times ☐ I don't take medicines
16)	About how many times **in the last month** have you taken your medication differently than prescribed by your doctor? (skip if you don't take medicines)	_____ times
17)	Do you take any over-the-counter medications (vitamins, supplements, herbal medicines)?	☐ Yes ☐ No
18)	Do you have sufficient transportation to make all of your medical appointments?	☐ 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 times?_____	☐ Yes ☐ No
20)	In the **past 6 months**, have you had a problem with leakage of urine?	☐ Yes ☐ No
21)	In the **past month**, have you needed help managing your finances?	☐ Yes ☐ No
22)	Do you think anybody is taking or using your money without your permission?	☐ Yes ☐ No
23)	In the **past 7 days**, have you needed help from others:	
24)	To eat, bathe, get dressed or use the toilet?	☐ Yes ☐ No
25)	To do laundry, cooking, housekeeping or shopping?	☐ Yes ☐ No
26)	For transportation?	☐ Yes ☐ No
27)	To take your medications?	☐ Yes ☐ No
28)	Do you or your caregiver have sufficient help/support with and resources for caregiving duties? (skip if you do not give or receive care)	☐ Yes ☐ No
29)	Are you satisfied with your current level of social interaction with family and friends, and participation in activities outside your home?	☐ Yes ☐ No
30)	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
31)	Is anybody mistreating you?	☐ Yes ☐ No
32)	Do you have an Advance Directive or Living Will?	☐ Yes ☐ No

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

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

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 _____