

Health Risk Assessment



Get ready to create your personal care plan!

Your health plan offers many resources and services to help you achieve your best health. A Health Risk Assessment can help us identify the best types of support for you — and help you learn more about your health so you can create a personal care plan for the year.

What is a Health Risk Assessment?

A Health Risk Assessment asks questions about your health and lifestyle habits, risk factors and your mental, social and emotional health. It should take you less than 20 minutes to complete. Your honest answers to these questions will inform your care team about the best education, resources and services we can offer you to support your individual health.

TERMS OF USE

Completing your Health Risk Assessment is a big step toward better health! First, you will need to review and agree to a few Terms of Use.

Your Data Is Private

Your health plan is required by law to ensure the privacy of your protected health information, also called PHI. Please refer to your Plan Documents to review our Notice of Privacy Practices for information regarding rights relating to your protected health information.

How Your Data May Be Used

Your data may be shared in one of two forms:

1. Data that does *not* show who you are (this is called “aggregate data”)
2. Data that does show who you are

When you agree to these Terms of Use, understand that your data may be shared with approved staff for different purposes, such as:

- **Care Management:** To identify members who may benefit from additional health support programs or services
- **Quality Improvement:** To help us improve our health programs and services for all members
- **Aggregate Analysis:** Your information may be combined with other members' information (with all identifying information removed) for research and program evaluation purposes
- **Required Reporting:** As required by law or regulation for public health reporting or quality measures

You can opt out at any time. However, your aggregate data will stay in our system.

How You Should Use Your Results

You may request a copy of your Health Risk Assessment results by contacting your health plan's Member Services team. These results are not a diagnosis of illness or a recommendation for treatment. They should only be used as a reference and considerations for how to improve your health.

Health Risk Assessment



Remember:

- Talk to your doctor about any lab or test results and any concerns you have.
- You should never use the results to label or treat a disease.
- Talk with a doctor if you have any sign of health problems.
- Talk to your doctor about your results to see how they can be useful in your health care.
- Talk with a doctor if any lab test results are not normal.

Keep in mind that you are in charge of your own health. It is up to you to talk with your doctor if you have any questions or concerns about your health.

HEALTH RISK ASSESSMENT

By filling out this Health Risk Assessment, you agree that you have read the Terms of Use outlined above, you know what they mean and you consent to them.

Answer ALL questions unless otherwise indicated. Fill in blanks with BLOCK LETTERS. Use a dark pen or pencil.

My Information

Name

First: _____

Middle initial: _____

Last: _____

Member ID number

Plan name

Address

Address: _____

Address: _____

City: _____

State: _____

ZIP code: _____

Email address

(Used only for additional identity confirmation)

Contact information

Please provide at least one phone number

Home phone: _____

Mobile phone: _____

About Me

When were you born?

Month: _____ (Ex. 09)

Day: _____ (Ex. 01)

Year: _____ (Ex. 1976)

Sex at birth:

Male

Female

How do you rate your health?

Good

Fair

Poor

Over the last 2 weeks, how often have you been bothered by the following problems:

Little interest or pleasure in doing things?

Not at all

Several days

More than half the days

Nearly every day

Feeling down, depressed or hopeless?

Not at all

Several days

More than half the days

Nearly every day

In the last 4 weeks:

How much did poor health affect you?

Very little: No one noticed a change.

Some: You did a worse job or got less done.

A lot: You did at least a third less than normal.

Never or almost never

Sometimes

Often

How often did you feel stressed?

Stress can make you have tense muscles and headaches, be grumpy, feel nervous, and have a hard time sleeping.

Never or almost never

Sometimes

Often

How often did you feel angry?

Never or almost never

Sometimes

Often

Do you feel lonely?

Yes

No

Has it been hard for you to remember things that just happened?

Yes

No

Do people tell you that you say the same things over and over?

Yes

No

Have you gotten lost in places you know really well?

Yes

No

How well do you cope with stress in your life?

Cope well most of the time

Sometimes don't cope well

Often have a hard time coping

Do you want to cope with stress better?

Coping means how you deal with tough problems and things that upset you.

Not interested

Yes, but not right now

Yes, I'm ready

I've recently improved how I manage stress

I've been managing stress for more than 6 months

My Health

How many hours of sleep do you get each night?

Hours: _____

How tall are you?

Feet: _____

Inches: _____

How much do you weigh?

Pounds: _____

Are you interested in losing weight?

<input type="checkbox"/> Not interested	<input type="checkbox"/> Yes, but not right now	<input type="checkbox"/> Yes, I'm ready
<input type="checkbox"/> I've recently achieved a healthy weight	<input type="checkbox"/> I've had a healthy weight for more than 6 months	

Do you want to improve your food choices for your health?

<input type="checkbox"/> Not interested	<input type="checkbox"/> Yes, but not right now	<input type="checkbox"/> Yes, I'm ready
<input type="checkbox"/> I recently started making healthy food choices	<input type="checkbox"/> I have been making healthy food choices for more than 6 months	

Do you want to get more exercise?

<input type="checkbox"/> Not interested	<input type="checkbox"/> Yes, but not right now	<input type="checkbox"/> Yes, I'm ready
<input type="checkbox"/> I recently became more physically active	<input type="checkbox"/> I've been physically active for more than 6 months	

Has your doctor ever said you have, or had in the past, any of these health conditions?

Heart Disease

Angina or chest pain, heart attack, angioplasty, coronary artery bypass surgery

Stroke

Includes restricted blood flow to the head

Diabetes

Or taking medication for high blood sugar

Cancer

Other than minor skin cancer

Lung problem

Emphysema, chronic bronchitis, COPD

Osteoporosis

A disease that causes weak bones that can break easily

Arthritis

You have pain or feel stiff in your joints (like knee or wrist)

High blood pressure

High blood pressure = 140+/90 or taking medication

Hearing problem

Hearing loss that can't be made better with a hearing aid

Vision problem

Poor eyesight that can't be made better with glasses or contacts

No	Yes, in the past	Yes, now
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to the above, are you currently receiving treatment?

I am being treated now

	Yes	No
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Lung problem	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problem	<input type="checkbox"/>	<input type="checkbox"/>
Vision problem	<input type="checkbox"/>	<input type="checkbox"/>

In the past month, how much physical pain have you felt?

Mild pain is like pain from being pinched or getting a shot. Bad pain is how a toothache or sprained ankle feels. You might need mild pain pills (like aspirin). Very bad pain is how it feels when you break a bone. The pain is so bad you need strong pain pills ordered by your doctor.

<input type="checkbox"/> No pain	<input type="checkbox"/> Mild pain	<input type="checkbox"/> Bad pain	<input type="checkbox"/> Very bad pain
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Are you interested in lowering your blood pressure?

<input type="checkbox"/> Not interested	<input type="checkbox"/> Yes, but not right now	<input type="checkbox"/> Yes, I'm ready
<input type="checkbox"/> I've recently lowered my blood pressure	<input type="checkbox"/> I've had a healthy blood pressure for more than 6 months	

Are you interested in improving your cholesterol?

<input type="checkbox"/> Not interested	<input type="checkbox"/> Yes, but not right now	<input type="checkbox"/> Yes, I'm ready
<input type="checkbox"/> I've recently lowered my cholesterol	<input type="checkbox"/> I've had a healthy cholesterol level for more than 6 months	

Are you interested in lowering your blood sugar level?

<input type="checkbox"/> Not interested	<input type="checkbox"/> Yes, but not right now	<input type="checkbox"/> Yes, I'm ready
<input type="checkbox"/> I've recently lowered my blood sugar level	<input type="checkbox"/> I've had a healthy blood sugar level for more than 6 months	

Tobacco & Alcohol

Do you use any kind of tobacco or e-cigarettes?

- Yes No, I never have No, I quit

Do you want to quit tobacco?

- | | | |
|---|--|---|
| <input type="checkbox"/> Not interested | <input type="checkbox"/> Yes, but not right now | <input type="checkbox"/> Yes, I'm ready |
| <input type="checkbox"/> I've recently quit using tobacco | <input type="checkbox"/> I've been tobacco-free for more than 6 months, or have never used tobacco | |

Do you ever drink alcohol?

- Yes No

If you answered Yes, please also answer the following questions:

How often do you have a drink of alcohol?

- | | | |
|--|---|---|
| <input type="checkbox"/> Never | <input type="checkbox"/> Monthly or less | <input type="checkbox"/> 2 to 4 times a month |
| <input type="checkbox"/> 2 to 3 times a week | <input type="checkbox"/> 4 or more times a week | |

How many drinks containing alcohol do you have on a typical day when you are drinking?

1 drink = 12 oz. beer; 8 oz. malt liquor; or 1 1/2 oz. gin, rum, whiskey, vodka, etc. 1 glass = 5 oz. wine.

- | | | |
|---------------------------------|-------------------------------------|---|
| <input type="checkbox"/> 1 or 2 | <input type="checkbox"/> 3 or 4 | <input type="checkbox"/> 5 or 6 |
| <input type="checkbox"/> 7 to 9 | <input type="checkbox"/> 10 or more | <input type="checkbox"/> I do not drink alcohol |

How often do you have 6 or more drinks on one occasion?

- | | | |
|---------------------------------|--|---|
| <input type="checkbox"/> Never | <input type="checkbox"/> Less than monthly | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Weekly | <input type="checkbox"/> Daily or almost daily | <input type="checkbox"/> I do not drink alcohol |

Are you interested in drinking less or quitting all together?

<input type="checkbox"/> Not interested	<input type="checkbox"/> Yes, but not right now	<input type="checkbox"/> Yes, I'm ready
<input type="checkbox"/> I've recently quit drinking alcohol	<input type="checkbox"/> I've been a non-drinker for more than 6 months, or have never used alcohol	

My Activities

Do you need help to do these things?

	Yes	No
Getting ready for the day <i>Such as when you shave, brush or comb your hair, put on makeup, brush your teeth or trim your nails</i>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with your teeth or trouble chewing food?	<input type="checkbox"/>	<input type="checkbox"/>
Getting to the toilet	<input type="checkbox"/>	<input type="checkbox"/>
Getting in or out of bed/chair	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>
Taking a bath or shower	<input type="checkbox"/>	<input type="checkbox"/>
Cooking meals	<input type="checkbox"/>	<input type="checkbox"/>
Cleaning the house <i>Such as when you mop, vacuum or wash windows</i>	<input type="checkbox"/>	<input type="checkbox"/>
Keeping the house tidy <i>Such as when you do dishes, tidy a room or make a bed</i>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>
Doing the laundry	<input type="checkbox"/>	<input type="checkbox"/>
Using the phone	<input type="checkbox"/>	<input type="checkbox"/>
Taking your medicine	<input type="checkbox"/>	<input type="checkbox"/>
Taking care of your money	<input type="checkbox"/>	<input type="checkbox"/>

How many times have you fallen in the past 6 months?

None

Once

More than once

Within that past 12 months, you worried that your food would run out before you got the money to buy more.

Never true

Sometimes true

Often true

Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

Never true

Sometimes true

Often true

In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?

Yes

No

In the past 12 months, has lack of transportation kept you from meetings, work, or from getting things needed for daily living?

Yes

No

What is your living situation today?

I have a steady place to live

I have a place to live today, but I am worried about losing it in the future

I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

At any time in the past 12 months, were you homeless or living in a shelter (including now)?

Yes

No

In the past 12 months, how many times have you moved where you were living?

_____ times

In the past 12 months, was there a time when you were not able to pay the mortgage or rent on time?

Yes

No

Congratulations! You're finished.

If you have any questions, please contact your health plan's Member Services team.

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