

# Health Risk Assessment



An Independent Licensee of the Blue Cross Blue Shield Association

Health  
Choice

Please complete the following questions the best that you can. Your answers will not affect your Medicaid or Medicare benefits. The information will be treated with confidentiality and will help us learn more about your health needs. Information you provide may be reviewed by a care manager and may be shared with your primary care doctor, behavioral health clinic, or other members of your team. Completion of this form implies that you agree to have this used for this purpose.

## IMPORTANT:

Be sure to complete your Name and Member ID. This information will help us know who you are.

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medicaid/Medicare ID Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Race or Ethnicity:	
<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African American
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Hispanic/Latino
<input type="checkbox"/> Native American/Alaska Native	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
<input type="checkbox"/> Other _____	<input type="checkbox"/> Decline to answer

What is your preferred Language:	
<input type="checkbox"/> English	<input type="checkbox"/> Korean
<input type="checkbox"/> Spanish	<input type="checkbox"/> Polish
<input type="checkbox"/> Arabic	<input type="checkbox"/> Portuguese
<input type="checkbox"/> Chinese (incl. Cantonese, Mandarin)	<input type="checkbox"/> Russian
<input type="checkbox"/> French	<input type="checkbox"/> Tagalog
<input type="checkbox"/> German	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Hindi	<input type="checkbox"/> Decline to answer
<input type="checkbox"/> Italian	<input type="checkbox"/> Other _____
<input type="checkbox"/> Japanese	

We are interested in honoring your values and beliefs. Do you have any cultural preferences we should know about that may impact your health care?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Decline to answer
What are your preferences? _____		

## Contact Information

How would you prefer to be contacted?

- Mail                       Phone                       Cell                       Text                       Email

List contact information: \_\_\_\_\_

## Level of Education

What is the highest grade or level of school that you completed?

- 8th grade or less     Some high school  
 High school graduate or GED     Some college  
 College graduate     More than a 4 year college graduate  
 Decline to answer

## What medical conditions do you have? Select all that apply

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Allergic rhinitis                | <input type="checkbox"/> Anticoagulation therapy           | <input type="checkbox"/> Anxiety                             |
| <input type="checkbox"/> Arthritis                        | <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Atrial fibrillation                 |
| <input type="checkbox"/> Autoimmune disease               | <input type="checkbox"/> Benign prostatic Hypertrophy      | <input type="checkbox"/> Bipolar disorder                    |
| <input type="checkbox"/> Cancer (Active)                  | <input type="checkbox"/> Cancer - Leukemia                 | <input type="checkbox"/> Cancer - Lymphoma                   |
| <input type="checkbox"/> Cancer - Solid tumor (Localized) | <input type="checkbox"/> Cancer - Solid tumor (Metastatic) | <input type="checkbox"/> Chronic Kidney disease (Mod-Severe) |
| <input type="checkbox"/> Chronic pain                     | <input type="checkbox"/> Congestive heart failure          | <input type="checkbox"/> COPD/Emphysema                      |
| <input type="checkbox"/> COVID-19                         | <input type="checkbox"/> CVA with hemiplegia               | <input type="checkbox"/> Dementia                            |
| <input type="checkbox"/> Depression                       | <input type="checkbox"/> Diabetes - Uncomplicated          | <input type="checkbox"/> Diabetes - End organ damage         |
| <input type="checkbox"/> Dialysis                         | <input type="checkbox"/> End Stage Renal Disease           | <input type="checkbox"/> Fall Risk                           |
| <input type="checkbox"/> Gout                             | <input type="checkbox"/> Headaches                         | <input type="checkbox"/> Hearing problems                    |
| <input type="checkbox"/> Heart Disease                    | <input type="checkbox"/> Hepatitis                         | <input type="checkbox"/> High blood pressure                 |
| <input type="checkbox"/> High cholesterol                 | <input type="checkbox"/> Home oxygen                       | <input type="checkbox"/> Hypothyroidism                      |
| <input type="checkbox"/> Joint pain                       | <input type="checkbox"/> Kidney Disease - Mod-Severe       | <input type="checkbox"/> Kidney failure                      |
| <input type="checkbox"/> Liver Disease - Mild             | <input type="checkbox"/> Liver Disease - Mod-Severe        | <input type="checkbox"/> Malaise and fatigue                 |
| <input type="checkbox"/> Migraines                        | <input type="checkbox"/> Neurologic disease                | <input type="checkbox"/> Narcotic Use                        |
| <input type="checkbox"/> Obesity                          | <input type="checkbox"/> Organ transplant                  | <input type="checkbox"/> Osteoporosis                        |
| <input type="checkbox"/> Peripheral Neuropathy            | <input type="checkbox"/> Reflux esophagitis                | <input type="checkbox"/> Respiratory problems                |
| <input type="checkbox"/> Schizophrenia                    | <input type="checkbox"/> Seizures                          | <input type="checkbox"/> Sleep apnea                         |
| <input type="checkbox"/> Sleep problems                   | <input type="checkbox"/> Stroke                            | <input type="checkbox"/> Transient ischemia attack (TIA)     |
| <input type="checkbox"/> Urinary tract infection          | <input type="checkbox"/> Vision problems                   | <input type="checkbox"/> None                                |
| <input type="checkbox"/> Decline to answer                | <input type="checkbox"/> Other _____                       |  |



### Tobacco Use

Would you be interested in quitting tobacco use within the next month?

Yes       No       Unsure       Decline to answer

### Alcohol Use

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

\_\_\_\_\_ Days       Decline to answer

On days when you drank alcohol, how often did you have:

- Men under 65 years old - 5 or more alcoholic drinks on one occasion
- Men 65 years old - 4 or more alcoholic drinks on one occasion
- Women any age - 4 more alcoholic drinks on one occasion

Never       Once during the week  
 2-3 times during the week       More than 3 times during the week  
 Decline to answer

Do you ever drive after drinking or ride with a driver who has been drinking?

Yes       No       Decline to answer

### Other Substance Use

Have you used any illegal drugs or prescription drugs for non-medical reasons?

Yes       No       Decline to answer

### Nutrition

In the past 7 days, how many servings of fruit and vegetables did you typically eat each day?  
(1 serving = 1 cup of fresh vegetables, 1/2 cup of cooked vegetables, or 1 medium piece of fruit.  
1 cup = size of a baseball)

\_\_\_\_\_ Servings per day       Decline to answer

In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day?  
(1 serving= 1 slice of 100% whole wheat bread, 1 cup of whole grain or high-fiber ready-to-eat cereal,  
1/2 cup of cooked cereal such as oatmeal, or 1/2 cup of cooked brown rice or whole wheat pasta)

\_\_\_\_\_ Servings per day       Decline to answer

In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day?  
(examples include: fried chicken, fried fish, bacon, French fries, potato chips, corn chips, donuts,  
creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise)

\_\_\_\_\_ Servings per day       Decline to answer

In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?

\_\_\_\_\_ Sugar-sweetened beverages consumed per day       Decline to answer

Do you want to change your eating habits to be more healthy?

Not interested       Yes, but not right now       Yes, I'm ready  
 Decline to answer

## Depression

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

- Almost all the time                       Most of the time                       Some of the time  
 Almost never                               Decline to answer

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

- Almost all the time                       Most of the time                       Some of the time  
 Almost never                               Decline to answer

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

- Yes                       No                       Decline to answer

Are you actively seeing a behavioral health provider?

- Yes                       No                       Decline to answer

In the past few weeks, have you wished you were dead?

- Yes                       No                       Decline to answer

In the past few weeks, have you felt that you or your family would be better off if you were dead?

- Yes                       No                       Decline to answer

Suicide Prevention Hotline Information:

24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454

24/7 Crisis Text Line: Text "HOME" to 741-741

## Anxiety

In the past 2 weeks, how often have you felt nervous, anxious, or on edge?

- Almost all the time                       Most of the time                       Some of the time  
 Almost never                               Decline to answer

In the past 2 weeks, how often were you not able to stop worrying or control your worrying?

- Almost all the time                       Most of the time                       Some of the time  
 Almost never                               Decline to answer

## High Stress

How often is stress a problem for you in handling such things as:

Your health?

- |  |  |                                |
|--|--|--------------------------------|
| <input type="checkbox"/> Never or rarely | <input type="checkbox"/> Sometimes         | <input type="checkbox"/> Often |
| <input type="checkbox"/> Always          | <input type="checkbox"/> Decline to answer |                                |

Your finances?

- |  |  |                                |
|--|--|--------------------------------|
| <input type="checkbox"/> Never or rarely | <input type="checkbox"/> Sometimes         | <input type="checkbox"/> Often |
| <input type="checkbox"/> Always          | <input type="checkbox"/> Decline to answer |                                |

Your family or social relationships?

- |  |  |                                |
|--|--|--------------------------------|
| <input type="checkbox"/> Never or rarely | <input type="checkbox"/> Sometimes         | <input type="checkbox"/> Often |
| <input type="checkbox"/> Always          | <input type="checkbox"/> Decline to answer |                                |

Your work?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Never or rarely | <input type="checkbox"/> Sometimes           | <input type="checkbox"/> Often             |
| <input type="checkbox"/> Always          | <input type="checkbox"/> Not working/Retired | <input type="checkbox"/> Decline to answer |

## Social/Emotional Support

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

- |                                 |                                  |  |
|---------------------------------|----------------------------------|--|
| <input type="checkbox"/> Always | <input type="checkbox"/> Usually | <input type="checkbox"/> Sometimes         |
| <input type="checkbox"/> Rarely | <input type="checkbox"/> Never   | <input type="checkbox"/> Decline to answer |

## Pain

In the past 7 days, how much pain have you felt? (Scale of 0-10)

- |                                   |                                     |   |  |  |
|-----------------------------------|-------------------------------------|---|--|--|
| <input type="checkbox"/> None (0) | <input type="checkbox"/> Mild (1-3) | <input type="checkbox"/> Moderate (4-6) | <input type="checkbox"/> Severe (7-10) | <input type="checkbox"/> Decline to answer |
|-----------------------------------|-------------------------------------|---|--|--|

Describe the pain and where it is located:

---

## General Health

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      | <input type="checkbox"/> Decline to answer |

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

- |                                    |                                    |  |
|------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Very good | <input type="checkbox"/> Good              |
| <input type="checkbox"/> Fair      | <input type="checkbox"/> Poor      | <input type="checkbox"/> Decline to answer |

Are you currently pregnant?

- |   |  |                                  |
|---|--|----------------------------------|
| <input type="checkbox"/> Yes            | <input type="checkbox"/> No                | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Not applicable | <input type="checkbox"/> Decline to answer |                                  |

### How confident are you filling out medical forms by yourself?

- |                                       |                                      |  |
|---------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Extremely    | <input type="checkbox"/> Quite a bit | <input type="checkbox"/> Somewhat          |
| <input type="checkbox"/> A little bit | <input type="checkbox"/> Not at all  | <input type="checkbox"/> Decline to answer |

### Activities of Daily Living

In the past 7 days, did you need help from others to perform everyday activities such as:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Continence                                    | <input type="checkbox"/> Dressing                   | <input type="checkbox"/> Eating             |
| <input type="checkbox"/> Getting in/out of bed,<br>chair or wheelchair | <input type="checkbox"/> Grooming/Bathing           | <input type="checkbox"/> Using toilet       |
| <input type="checkbox"/> Walking                                       | <input type="checkbox"/> None-Don't need assistance | <input type="checkbox"/> Declined to answer |

### Instrumental Activities of Daily Living

In the past 7 days, did you need help from others to take care of things such as:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Banking            | <input type="checkbox"/> Food preparation    | <input type="checkbox"/> Housekeeping                |
| <input type="checkbox"/> Laundry            | <input type="checkbox"/> Shopping            | <input type="checkbox"/> Taking your own medications |
| <input type="checkbox"/> Transportation     | <input type="checkbox"/> Using the telephone | <input type="checkbox"/> None-Don't need assistance  |
| <input type="checkbox"/> Declined to answer |  |  |

### Sexual Health

Do you use protection such as condoms during sex?

- Yes                       No                       Sometimes                       Decline to answer

Do you take medications for sexually transmitted disease?

If so, what is it? \_\_\_\_\_

- Yes                                       No                                       Decline to answer

### Social and Other Needs

Are you a Veteran?

- Yes                       No                       Decline to answer

### Food

Within the past 12 months, did you worry that your food would run out before you got money to buy more?

- Yes                       No                       Decline to answer

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

- Yes                       No                       Decline to answer

## Housing/Utilities

Do you have housing? (Own, Rent, Apartment, Staying with family/friends)

Yes                       No                       Decline to answer

Are you worried about losing your housing?

Yes                       No                       Decline to answer

Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed?

Yes                       No                       Decline to answer

## Work

During the past 4 weeks, has your health impacted your ability to work or caused you to be absent from activities you enjoy?

Not at all                       A little bit                       Moderately  
 Quite a bit                       Extremely                       Decline to answer  
 Retired/Not working

## Transportation

Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need?

Yes                       No                       Decline to answer

## Interpersonal Safety

Do you feel physically and emotionally safe where you currently live?

Yes                       No                       Decline to answer

Within the past 12 months, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

Yes                       No                       Decline to answer

Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?

Yes                       No                       Decline to answer

Do you always fasten your seat belt when you are in the car?

Yes                       No                       Decline to answer

## Sleep

Each night, how many hours of sleep do you usually get? \_\_\_\_\_  Decline to answer

Do you snore, or has anyone told you that you snore?

Yes                       No                       Decline to answer

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

Always                       Usually                       Sometimes  
 Rarely                       Never                       Decline to answer



### Blood Pressure

If your blood pressure was checked within the past year, what was it when it was last checked?

- Low (at or below 120/80)       Borderline (121/81 to 139/89)       High (140/90 or higher)  
 Don't know/not sure       Decline to answer

### Cholesterol

If your cholesterol was checked within the past year, what was your total cholesterol when it was last checked?

- Desirable (below 200)       Borderline high (200-239)       High (240 or higher)  
 Don't know/not sure       Decline to answer

### Blood Glucose

If your glucose was checked, what was your fasting blood glucose (blood sugar) level the last time it was checked?

- Desirable (below 100)       Borderline (100-125)       High (126 or higher)  
 Don't know/not sure       Decline to answer

If diabetic, and you have had your hemoglobin A1c level checked in the past year, what was it the last time you had it checked?

- Desirable (6 or lower)       Borderline high (7)       High (8 or higher)  
 Don't know/not sure       Not Diabetic       Decline to answer  
 Diabetic but have not been tested in the last year

### Height and Weight

What is your height? \_\_\_\_\_  Decline to answer      What is your weight? \_\_\_\_\_  Decline to answer

Do you want to work on getting to a healthy weight?

- I'm already at a healthy weight       Not interested       Yes, but not right now  
 Yes, I'm ready       Decline to answer

## Your Health Care in the Last 6 Months

What is the name of your Primary Care Physician or Clinic? \_\_\_\_\_

Using any number from 0 to 10, where 0 is the worst and 10 is the best, what number would you use to rate your Primary Care Physician or Clinic? Please circle your response.

Worst                      Neutral                      Best  
0 1 2 3 4 5 6 7 8 9 10                       Decline to answer

Are you actively participating in services at a Behavioral Health Home or Clinic?

Yes                       No                       Decline to answer

What is the name of your Behavioral Health Home or Clinic? \_\_\_\_\_

Using any number from 0 to 10, where 0 is the worst and 10 is the best, what number would you use to rate your Behavioral Health Home or Clinic? Please circle your response.

Worst                      Neutral                      Best  
0 1 2 3 4 5 6 7 8 9 10                       Decline to answer

In the past 6 months, how many times did you visit the Emergency Department?

None                                       1 time                                       2-3 times  
 4-5 times                                       6 or more times                                       Decline to answer

In the past 6 months, how many times did you have to stay overnight (one or more nights) at any hospital?

None                                       1 time                                       2-3 times  
 4-5 times                                       6 or more times                                       Decline to answer

Have you had any past hospitalizations or major procedures, like surgery in the past 5 years?

Yes                       No                       Unsure                       Decline to answer

What were your hospitalizations/procedures, and what were they for?

\_\_\_\_\_  
\_\_\_\_\_

When were these past hospitalizations/procedures?

\_\_\_\_\_  
\_\_\_\_\_

When was the last time you had a breast cancer screening (mammogram)?

In the last year                       In the last 2-4 years                       In the last 5 years  
 Greater than 5 years                       Never                       Not applicable  
 Do not remember when                       Decline to answer

## Your Health Care in the Last 6 Months

When was the last time you had a colorectal cancer screening (colonoscopy, sigmoidoscopy, or FIT test)?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> In the last year     | <input type="checkbox"/> In the last 2-4 years | <input type="checkbox"/> In the last 5 years |
| <input type="checkbox"/> Greater than 5 years | <input type="checkbox"/> Never                 | <input type="checkbox"/> Not applicable      |
| <input type="checkbox"/> Do not remember when | <input type="checkbox"/> Decline to answer     |  |

When was the last time you had a cervical cancer screening (PAP smear)?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> In the last year     | <input type="checkbox"/> In the last 2-4 years | <input type="checkbox"/> In the last 5 years |
| <input type="checkbox"/> Greater than 5 years | <input type="checkbox"/> Never                 | <input type="checkbox"/> Not applicable      |
| <input type="checkbox"/> Do not remember when | <input type="checkbox"/> Decline to answer     |  |

When was the last time you had a pneumonia vaccine?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> In the last year     | <input type="checkbox"/> In the last 2-4 years | <input type="checkbox"/> In the last 5 years |
| <input type="checkbox"/> Greater than 5 years | <input type="checkbox"/> Never                 | <input type="checkbox"/> Not applicable      |
| <input type="checkbox"/> Do not remember when | <input type="checkbox"/> Decline to answer     |  |

Have you had a flu shot this year or are you planning to receive one this year?

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Decline to answer |
|------------------------------|-----------------------------|--|

Have you had a COVID vaccination?

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Decline to answer |
|------------------------------|-----------------------------|--|

Have you had Monoclonal antibody treatment? (only administered if positive for COVID-19)

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Decline to answer |
|------------------------------|-----------------------------|--|

Do you have an Advanced Directive?

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Decline to answer |
|------------------------------|-----------------------------|--|

Which type?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Living Will                         | <input type="checkbox"/> Health care proxy | <input type="checkbox"/> Durable power of attorney |
| <input type="checkbox"/> Behavioral health power of attorney | <input type="checkbox"/> MOLST/POLST       |  |
| <input type="checkbox"/> Unsure which on                     | <input type="checkbox"/> Other: _____      |  |

Do you have any specific health concerns your health plan team can assist with? Interdisciplinary Care Team (ICT) is an important component of your integrated care program. The ICT can consist of you, your provider, other specialist, care manager, family members, medical director, and behavioral health professionals as needed to develop your care plan. Would you like to participate in the ICT?

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Decline to answer |
|------------------------------|-----------------------------|--|

*Evidenced Based Sources for HRA Development: American College of Cardiology; American Diabetes Association: Standards of Care in Diabetes; Centers for Disease Control and Prevention (CDC); Centers for Medicare & Medicaid Services (CMS); Institute of Medicine (IOM). Dietary Reference Intakes (DRIs); National Heart, Lung, and Blood Institute (NHLBI) guidelines for heart health (Adult Treatment Panel III (ATP III) Guidelines); U.S. Department of Health and Human Services. Physical Activity Guidelines for American; U.S. Department of Agriculture (USDA). Dietary Guidelines for Americans; National Institute of Health (NIH). Prevention, Detection, Evaluation, and Treatment of High Blood Pressure; American College of Preventive Medicine (ACPM); ASAM Criteria; SAMHSA. Effective 2019-2020*