Health Risk Screening (Age 18 and older)

Please answer all the questions. Use a different form for each adult.

network health

First Name _____ Last Name _____

Date of Birth _____ Member ID # _____

Preferred Mailing Address _____

_____

Preferred Phone Number _____ Preferred Email _____

Race

☐ Asian
☐ White
☐ Unknown
☐ Decline to answer
☐ American Indian/Alaska Native
☐ Black/African American
☐ Native Hawaiian/Pacific Islander
☐ Other _____

Ethnicity

☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Unknown
☐ Decline to answer
☐ Other _____

Preferred Language

☐ English
☐ Spanish
☐ Other _____

Are you American Indian?

☐ Yes ☐ No ☐ Unknown ☐ Decline to answer

If yes, are you eligible to receive Indian Health Services?

☐ Yes ☐ No ☐ Unknown ☐ Decline to answer

What is your gender identity? (Please select all that apply.)

☐ Female ☐ Male ☐ Non-binary (Don't identify as either) ☐ Transgender ☐ Unknown ☐ Decline to answer

What is the highest level of education you have completed?

☐ No schooling completed ☐ Grade school to 8th grade ☐ Some high school, no diploma ☐ High school graduate, diploma, or equivalent (GED, etc.) ☐ Some college credit, no degree

☐ Trade/Technical/Vocational training ☐ Associate Degree ☐ Bachelor's Degree ☐ Master's Degree

☐ Doctorate Degree or equivalent ☐ Decline to answer ☐ Unknown

Do you have any religious, spiritual, or cultural beliefs that impact your health care?

☐ Yes ☐ No ☐ Decline to answer

If yes, please explain: _____

Do you find it hard to understand what your doctor tells you about your health?

☐ Yes ☐ No ☐ Decline to answer

If yes, please explain: _____

Do you need help from others to understand written materials or with filling out medical forms?

☐ Yes ☐ No ☐ Decline to answer

If yes, please explain: _____

Do you need any information on a Living Will or Power of Attorney for Health Care?

☐ Yes ☐ No ☐ I already have them complete and on file ☐ Unknown ☐ Decline to answer

If yes, please explain: _____

GLOBAL HEALTH AND SAFETY

In general, how would you rate your health:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Unknown

If poor, please explain: _____

How ready are you to make changes for your health?

☐ Not ready to change ☐ Unsure ☐ Ready for change ☐ No changes needed ☐ Unknown

If you are ready for a change, what changes are you ready to make for your health?

_____

Do you have a doctor or health care provider?

☐ Yes What is your provider's name? _____

ⓘ Regular wellness exams can help make sure you stay as healthy as you can.

Have you seen your provider in the last 12 months? ☐ Yes ☐ No ☐ Unknown

If yes, what did you see your provider for? ☐ Preventative care/wellness visit ☐ Sick care visit

☐ Follow up after being in the hospital ☐ Follow up after emergency room visit ☐ Other

If other, what was the visit for? _____

ⓘ It is important to identify a doctor or health care provider to help you stay healthy and in case you get sick.

Do you need help find a primary doctor or health care provider? ☐ Yes ☐ No

How many times have you been in the hospital in the last 3 months?

☐ None ☐ 1 time ☐ 2 times ☐ More than 3 times ☐ Unknown

List reason(s) for hospital visit(s): _____

How many times have you been to the emergency room in the last 3 months?

☐ None ☐ 1 time ☐ 2 times ☐ More than 3 times ☐ Unknown

List reason(s) for emergency room visit(s): _____

How many medicines are you currently taking that were prescribed by your doctor or over the counter?

☐ None ☐ 1-3 prescriptions ☐ 4-7 prescriptions ☐ 8 or more prescriptions ☐ Unknown

Does anything prevent you from taking your medicines the way your doctor or health care provider wants you to?

☐ Yes ☐ No ☐ Unknown

If yes, what prevents you from taking your medicine? _____

Do you ever forget to take your medicine? ☐ Yes ☐ No ☐ Sometimes ☐ Unknown

Do you need help with your medications? ☐ Yes ☐ No ☐ Decline help

If yes, please explain: _____

When was the last time you saw a dentist?
☐ In last 6 months ☐ In last 12 months ☐ More than 12 months ☐ Never ☐ Unknown

Do you need help with getting dental care? ☐ Yes ☐ No ☐ Decline help ☐ N/A

What is your height? _____ feet _____ inches **What is your weight?** _____ pounds

Have you or a doctor or provider been concerned about your weight?
☐ Yes, overweight ☐ Yes, underweight ☐ No ☐ Unknown

If you said yes to a concern about being overweight, are you interested in losing weight? ☐ Yes ☐ No ☒ Unknown

Do you eat a healthy diet, such as eating fruits, vegetables, and whole grains every day? Do you limit sugar and saturated fats?
☐ Yes, most of the time ☐ Yes, sometimes ☐ No, not very often ☐ Unknown

If you don't eat a healthy diet, what prevents this? _____

_____

Do you participate in regular physical activity?
☐ Yes ☐ No ☐ I am unable to exercise due to medical conditions ☐ Unknown

If no, please explain: _____

Have you had a flu shot in the last 12 months? ☐ Yes ☐ No ☐ Unknown

If no, reason for not getting flu shot: _____

ⓘ Flu shots are recommended for everyone over 6 months of age every year. Getting an annual flu shot is the best way to protect yourself and your family from the flu.

What do you do to take care of yourself related to your health and wellbeing?

_____

_____

Have you had a COVID vaccination? ☐ Yes ☐ No ☐ Unknown

If no, reason for not getting COVID shot: _____

Do you have any health or personal goals for yourself? ☐ Yes ☐ No

If yes, what are your goals? _____

_____

What do you think are your strengths? _____

_____

Are you age 50 - 75? ☐ Yes ☐ No ☐ Unknown

If yes, have you been screened for colon cancer since you turned 50?

☐ Yes ☐ No ☐ N/A History of colon cancer or colectomy ☐ Unknown

Are you female? ☐ Yes ☐ No ☐ Unknown

If you are female, please continue to answer the questions below. If you are male, skip to Social Concerns section.

What is your age? ☐ 18-20 ☐ 21-24 ☐ 24-49 ☐ 50-64

Are sexually active now or have been in the past, have you had a test for a sexually transmitted infection (STI) like Chlamydia within the last year? Answer only if your age is 18-24.
☐ Yes ☐ No ☐ N/A No sexual history ☐ Unknown

Are you pregnant? Answer only if your age is 18-49. ☐ Yes, due date is _____ ☐ No ☐ Unknown

Have you had a PAP smear in the last 3 years? Answer only if your age is 21-64. ☐ Yes ☐ No ☐ Unknown

Do you get a mammogram to check for breast cancer at least every 2 years? Answer only if your age is 50-64.
☐ Yes ☐ No ☐ Unknown

SOCIAL CONCERNS

What are your sources of income? _____

_____

Do you currently have concerns about having enough money to pay for basic needs (rent, utilities, childcare, etc.)?
☐ Yes ☐ No ☐ Decline to answer
If yes, please explain concerns: _____

In the past 2 months have you been living in stable housing that you own, rent, or stay in as part of a household?
☐ Yes ☐ No ☐ Unknown
If no, please explain: _____

Do you always feel safe in your home and around all the people in your life?
☐ Yes ☐ No ☐ Unknown
If no, please explain: _____

Do you have access to a safe, reliable telephone? ☐ Yes ☐ No ☐ Unknown

Which of the following do you think you need help with at this time?

- Employment ☐ Yes ☐ No ☐ Decline to answer
  If yes, would you like paid or volunteer employment? ☐ Paid work ☐ Volunteer work
  Are you interested in information/resources for training or preparation for entering the workforce? ☐ Yes ☐ No
- **Transportation to medical appointments** ☐ Yes ☐ No ☐ Decline to answer
  If yes, what problems are you having and what help do you need? _____
  _____

- **Legal issues** ☐ Yes ☐ No ☐ Decline to answer
  If yes, what problems are you having and what help do you need? _____
  _____
- **Managing money** ☐ Yes ☐ No ☐ Decline to answer
  If yes, what problems are you having and what help do you need? _____
  _____
- **Utilities** ☐ Yes ☐ No ☐ Decline to answer
  If yes, what problems are you having and what help do you need? _____
  _____
- **Childcare** ☐ Yes ☐ No ☐ Decline to answer
  If yes, what problems are you having and what help do you need? _____
  _____
- **Shopping** ☐ Yes ☐ No ☐ Decline to answer
  If yes, what problems are you having and what help do you need? _____
  _____
- **Food** ☐ Yes ☐ No ☐ Decline to answer
  If yes, what problems are you having and what help do you need? _____
  _____
- **Overnight care** ☐ Yes ☐ No ☐ Decline to answer
  If yes, what problems are you having and what help do you need? _____
  _____
- **Remembering or understanding things** ☐ Yes ☐ No ☐ Decline to answer
  If yes, what problems are you having and what help do you need? _____
  _____

Do you have a primary caregiver who helps you on a regular basis? ☐ Yes ☐ No ☐ Unknown

If yes, are they doing a good job supporting your health care needs? ☐ Yes ☐ No ☐ Unknown

Who is your caregiver? ☐ Agency ☐ Family ☐ Friend ☐ Other

Agency caregiver's name _____ Phone number _____

Family caregiver's name _____ Phone number _____

Friend caregiver's name _____ Phone number _____

Other caregiver's name _____ Phone number _____

Do you have any relationships with community resources (case managers or other agencies)?
☐ Yes ☐ No ☐ Unknown

If yes, who are the community agencies you work with? _____

_____

PHYSICAL AND BEHAVIORAL HEALTH DIAGNOSES

Do you have any of the following? (Check all that apply.)

☐ Arthritis. Type _____	☐ Asthma as an adult	☐ COPD/Emphysema
☐ Hepatitis	☐ HIV	☐ Stroke
☐ Schizophrenia	☐ Eating disorder	☐ Cancer
☐ Learning Disability	☐ Depression	☐ Anxiety disorder
☐ Transplant	☐ Chronic kidney disease	☐ Heart disease
☐ High cholesterol	☐ High blood pressure	☐ Sickle cell disease (not trait)
☐ Diabetes	☐ Dementia	☐ Bipolar disorder

Do you have any problems with your hearing, vision, or speech requiring special services?
☐ Yes ☐ No ☐ Decline to answer ☐ Decline help

If yes, please explain problems and help needed: _____

Do you have any other conditions not listed above? _____

_____

In the past 7 days, have your health problems affected your ability to do your regular daily activities?
☐ Yes ☐ No ☐ Decline to answer ☐ Decline help

If yes, please explain problems and help needed: _____

Do you have any other health concerns? ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help

If yes, please explain problems and help needed: _____

Do you need help with any of the concerns you listed above? ☐ Yes ☐ No ☐ Decline to answer ☐ Decline help

If yes, please explain problems and help needed: _____

BEHAVIORAL HEALTH

In general, how satisfied you with your life are?
☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied ☐ Unknown

If very dissatisfied, please explain: _____

During the past month, have you often felt lonely?
☐ Yes ☐ No ☐ Unknown

During the past month, have you often felt down, depressed, or hopeless?
☐ Yes ☐ No ☐ Unknown

During the past month, have you often felt little interest or pleasure in doing things?
☐ Yes ☐ No ☐ Unknown

During the past year, how often did you have 5 or more alcoholic drinks in one day?
☐ Never ☐ 1-2 times ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐ Unknown

During the past year, how often did you use tobacco?
☐ Never ☐ 1-2 times ☐ Monthly ☐ Weekly ☐ Daily/almost daily ☐ Unknown
If yes, any interest in quitting within the next month? ☐ Yes ☐ No ☐ Unknown

During the past year, how often did you use prescription drugs for nonmedical reasons?
☐ Never ☐ 1-2 times ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐ Unknown

During the past year, how often did you use illegal drugs?
☐ Never ☐ 1-2 times ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐ Unknown

Do you have a personal history of substance misuse? ☐ Yes ☐ No ☐ Unknown
If yes, what type of personal misuse? _____

Have you received treatment for alcohol or substance misuse in the last 6 months?
☐ Yes ☐ No ☐ Unknown
If no, would you like help getting treatment? ☐ Yes ☐ No ☐ Unknown

Are you actively receiving treatment for a behavioral health disorder?
☐ Yes. My provider is _____ ☐ No ☐ Unknown
If no, would you like help getting treatment? ☐ Yes ☐ No ☐ Unknown

Do you often have trouble falling or staying asleep, or sleeping too much? ☐ Yes ☐ No ☐ Unknown
If yes, please explain: _____

What do you do to help you sleep? _____

_____

PAIN AND ACTIVITIES OF DAILY LIVING

During the last month, have you had pain that interfered with completion of housework or your ability to work outside the home?
☐ Yes ☐ No ☐ Unknown

If yes, what type of pain? _____

_____

Are you able to safely walk once in a standing position on a variety of surfaces? ☐ Yes ☐ No ☐ Unknown

Are you able to get into and out of bed or a chair by yourself? ☐ Yes ☐ No ☐ Unknown

Are you able to eat meals and snacks by mouth without help? ☐ Yes ☐ No ☐ Unknown

Are you able to take a bath or shower by yourself? ☐ Yes ☐ No ☐ Unknown

Are you able to dress yourself without help? ☐ Yes ☐ No ☐ Unknown

Are you able to get to and from the toilet or bedside commode? ☐ Yes ☐ No ☐ Unknown

Do you have complete self-control of your bowel and bladder functions? ☐ Yes ☐ No ☐ Unknown

Do you need help with any of the following daily activities: walking, getting out of a chair, eating, bathing, dressing, or going to the bathroom? ☐ Yes ☐ No ☐ Unknown

If yes, who helps you now? _____

Could you use extra help with these activities? ☐ Yes ☐ No ☐ Unknown

If yes, what type of help do you need? _____

_____

GENERAL INFORMATION

Assessment completed by: _____ Date: _____

Relationship to member: ☐ Self ☐ Member representative with permission ☐ Parent or guardian

Please be sure you answered all the questions.
Thank you for your time. We will be in touch with you.