

ANNUAL WELLNESS VISIT
Health Risk Assessment (HRA)



HEALTH STATUS

1. How would you rate your health in general?
- Excellent
 - Very Good
 - Good
 - Fair
 - Poor
2. Since your last office visit, do you feel your health has:
- Improved
 - Worsened
 - Stayed the same
3. What is your biggest health concern?
- _____

DIET & EXERCISE

4. How would you describe your current diet?
- Balanced
 - Diabetic
 - Gluten-free
 - Healthy
 - High fat
 - Low fat
 - High calorie
 - Low calorie
 - Low sodium
 - Vegetarian
5. How often do you exercise?
- None
 - Daily
 - Every other day
 - 3-4 days per week
 - Weekly
 - Monthly

Patient Name: _____

Patient Date of Birth: _____

Today's Date: _____

ACTIVITIES OF DAILY LIVING

6. Do you require assistance performing any of these daily activities?
- | | | |
|--------------------|------------------------------|-----------------------------|
| Dressing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Walking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Using the Toilet | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Handling Finances | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shopping | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Housekeeping | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Taking Medications | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

SAFETY

7. Do you wear your seatbelt in vehicles?
- Yes No
8. Do you wear a helmet while bicycling, etc.?
- Yes No N/A
9. Do you have smoke detectors in your home?
- Yes No

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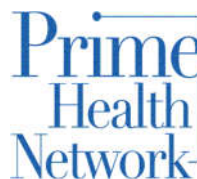


RISK FOR FALLING

I have fallen in the past year.	<input type="checkbox"/> Yes (2) How many times? _____	<input type="checkbox"/> No (0)
I use or have been advised to use a cane or walker to get around safely.	<input type="checkbox"/> Yes (2)	<input type="checkbox"/> No (0)
Sometimes I feel unsteady when I am walking.	<input type="checkbox"/> Yes (1)	<input type="checkbox"/> No (0)
I steady myself by holding onto furniture when walking at home.	<input type="checkbox"/> Yes (1)	<input type="checkbox"/> No (0)
I am worried about falling.	<input type="checkbox"/> Yes (1)	<input type="checkbox"/> No (0)
I need to push with my hands to stand up from a chair.	<input type="checkbox"/> Yes (1)	<input type="checkbox"/> No (0)
I have some trouble stepping up onto a curb.	<input type="checkbox"/> Yes (1)	<input type="checkbox"/> No (0)
I often have to rush to the toilet.	<input type="checkbox"/> Yes (1)	<input type="checkbox"/> No (0)
I have lost some feeling in my feet.	<input type="checkbox"/> Yes (1)	<input type="checkbox"/> No (0)
I take medicine that sometimes makes me feel light-headed or more tired than usual.	<input type="checkbox"/> Yes (1)	<input type="checkbox"/> No (0)
I take medicine to help me sleep or improve my mood.	<input type="checkbox"/> Yes (1)	<input type="checkbox"/> No (0)
I often feel sad or depressed.	<input type="checkbox"/> Yes (1)	<input type="checkbox"/> No (0)
<i>Add up the total points for each "Yes" answer</i>		

Scoring: If score is 4 points or more, at risk for falling

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Over the last 2 weeks, how often have you been bothered by any of the following problems? (use <input checked="" type="checkbox"/> to indicate your answer)	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	<input type="checkbox"/> Not difficult at all <input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult <input type="checkbox"/> Extremely difficult			
TO BE COMPLETED BY HEALTHCARE PROFESSIONAL: Add each column and total score	_____ + _____ + _____ Total: _____			

Scoring: 1 -4 Minimal • 5 – 9 Mild • 10 – 14 Moderate • 15 – 19 Moderately severe • 20 – 27 Severe

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1. How often do you have a drink containing alcohol?
 - a. Never
 - b. Monthly or less
 - c. 2-4 times a month
 - d. 2-3 times a week
 - e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
 - a. 1 or 2
 - b. 3 or 4
 - c. 5 or 6
 - d. 7 to 9
 - e. 10 or more

3. How often do you have six or more drinks on one occasion?
 - a. Never
 - b. Less than monthly
 - c. Monthly
 - d. Weekly
 - e. Daily or almost daily