ANNUAL WELLNESS VISIT
Health Risk Assessment (HRA)

Prime Health Network

Patient Name: _____

Patient Date of Birth: _____

Today's Date: _____

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

ACTIVITIES OF DAILY LIVING

6. Do you require assistance performing any of these daily activities?

Dressing	☐ Yes	☐ No
Bathing	☐ Yes	☐ No
Walking	☐ Yes	☐ No
Using the Toilet	☐ Yes	☐ No
Handling Finances	☐ Yes	☐ No
Shopping	☐ Yes	☐ No
Housekeeping	☐ Yes	☐ No
Taking Medications	☐ Yes	☐ 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

TOBACCO & ALCOHOL USE

10. Do you use tobacco?
☐ Yes ☐ No

If yes, how much per day? _____
_____

11. Do you use alcohol
☐ Yes ☐ No

If yes, Please answer the questionnaire on page 5

ADVANCE CARE PLANNING

12. Do you have a durable power of attorney?
☐ Yes ☐ No

13. Do you have a living will?
☐ Yes ☐ No

PLEASE LIST ANY PROVIDERS THAT YOU SEE OUTSIDE OF PRIME HEALTH NETWORK AND/OR ANY MEDICAL SUPPLY PROVIDER THAT YOU UTILIIZE

RISK FOR FALLING

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

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

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use ☑ 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.	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much.	☐	☐	☐	☐
4. Feeling tired or having little energy.	☐	☐	☐	☐
5. Poor appetite or overeating.	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
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.	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself.	☐	☐	☐	☐
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?	☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ 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

Cognitive-Function Screening (6CIT)

Ask Patient questions below: (use ☑ to indicate your answer score is listed)	**Correct**	**Incorrect**	**1 Error**	**1+ Error**
1. What year is it?	☐ (0)	☐ (4)		
2. What month is it?	☐ (0)	☐ (3)		
3. Ask patient to remember the address: John Brown, 42 West St, Bedford (make sure patient can repeat address properly and inform him/her that you will ask for it later)				
4. What time is it?	☐ (0)	☐ (3)		
5. Count backwards from 20 - 1	☐ (0)		☐ (2)	☐ (4)
6. Months of the year backwards	☐ (0)		☐ (2)	☐ (4)
7. Repeat previous memory phrase (address in #3) Scoring: 1 Error = (2) 2 Errors = (4) 3 Errors = (6) 4 Errors = (8) All incorrect = (10)	☐ (0)		☐ (2)	☐ see score
TO BE COMPLETED BY HEALTHCARE PROFESSIONAL: Add each column and total score	_____ + _____ + _____ Total: _____			

Scoring: 0 – 7 Normal • 8 – 9 Mild Cognitive Impairment • 10 – 28 Significant Cognitive Impairment

AUDIT-C Questionnaire

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