

# Health Risk Assessment



Please complete all sections that apply to you or your family member. The answers to these questions will help us see how we can best help you or your family member and will not affect your Medicaid benefits in any way. All answers **are kept private**.

## Member Information (\*Indicates a required question)

Name of person filling out the form: \_\_\_\_\_

Relationship to Member:

Self    Mother    Father    Grandparent    Foster Parent    Child    Other \_\_\_\_\_

\*Member Name (Last, First): \_\_\_\_\_

\*Medicaid ID: \_\_\_\_\_ Date of Birth (MMDDYYYY): \_\_\_\_\_

\*Gender:    Female    Male   Ethnicity:    Hispanic or Latino    Not Hispanic or Latino

Race (List up to two):

Black/African American    American Indian/Alaska Native    White    Asian

Native Hawaiian or Other Pacific Islander    Unknown/Not Specified

\*Spoken Language:    English    Spanish    Other \_\_\_\_\_

Written Language:    English    Spanish    Other \_\_\_\_\_

\*What is the best telephone number to reach you? \_\_\_\_\_

What type of phone number is this?    Home    Cell    Other \_\_\_\_\_

\*Best Email address? \_\_\_\_\_

\*How would you like us to contact you?    Phone    Mail    Email    Text

Other \_\_\_\_\_

\*Where do you live?    Own/Rent    Shelter    Homeless    Staying with family/friend

Other \_\_\_\_\_

How many places have you lived in the past year?    One    Two    Three or more

Do you feel safe at home?    Yes, always    Unsure    Yes, sometimes    No    Choose not to answer

Do you have a reliable transportation to doctor visits?    Always    Sometimes    Rarely or Never

Are you being treated for any of these conditions? (Check all that apply)

Acquired Brain Disorder    Asthma    Cancer    Diabetes    Heart Disease    HIV/AIDS

Intellectual or Developmental Disability    Lung Disease    Sickle Cell Disease (not trait)    Hepatitis

Serious Physical Condition (such as cerebral palsy, muscular dystrophy, multiple sclerosis, uncontrolled seizures)

Stroke    Transplant    Other (please explain) \_\_\_\_\_

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What health topics would you most like to address with your provider?

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Child Only

Juvenile Arthritis     Developmental Issues     Neonatal Abstinence Syndrome

Are you currently on IV antibiotics for more than 3 weeks?     Yes     No

Do you understand the medications you have been prescribed and when to take them?     Yes     No

Do you encounter barriers to taking your medications as prescribed?     Yes     No

Do you have constant pain?     Yes     No

If yes, how intense is the pain on a scale of 1 - 10 (10 being highest)

1     2     3     4     5     6     7     8     9     10

Have you ever experienced trauma or abuse? (e.g. being physically hurt by, humiliated, or emotionally abused by another person)?     Yes     No

If you ever experienced trauma or abuse, would you like support (e.g. to talk with a counselor)?

Yes     No

How often in the past 3 months were you worried that your food would run out?

Always     Sometimes     Rarely or Never

If completing for a child, does your child participate in any of the following?

Family Centered Early Supports and Services     Special Medical Services     Partners in Health     None

Are you pregnant?     Yes     No     N/A

If yes, are there pregnancy complications (ex. diabetes, high blood pressure or multiples)?

Yes     No     N/A

Have alcohol, prescription drugs or other substances been used during the pregnancy?

Yes     No     N/A

Are you being treated for any of these Mental Health or Substance Use conditions? (Check all that apply)

ADHD     Autism     Bipolar Disorder     Depression     Eating Disorder (anorexia, bulimia, other)

Schizophrenia     Serious Mental Illness     Substance Use Problems

Child Only     Serious Emotional Disturbance

Other \_\_\_\_\_

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Do you drink alcoholic beverages?     Yes     No     Choose not to answer

If yes, has anyone told you that your alcohol use is a problem?     Yes     No     Choose not to answer

Do you feel that you need help with drug or alcohol use?     Yes     No     Choose not to answer

Are you currently using street drugs (such as heroin, cocaine) or other drugs other than as prescribed?

Yes     No     Choose not to answer

Have you had an overdose in the past 12 months?  Yes  No

Do you smoke cigarettes, use smokeless tobacco, or vape?  Yes  No  Choose not to answer

Would you like to speak to someone about quitting?  Yes  No

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

Not at all  Several days  More than half of the days  Nearly every day

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

Not at all  Several days  More than half of the days  Nearly every day

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

Not at all  Several days  More than half of the days  Nearly every day

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

Not at all  Several days  More than half of the days  Nearly every day

Would you like to speak with someone about Mental Health/Substance use services?  Yes  No

Do you have difficulty doing the following activities by yourself? Check all that apply.

Bathing  Dressing  Walking  Eating  Using the toilet  Getting in and out chair

Preparing meals  Managing Money  Taking medication as prescribed  Performing home chores

Grocery Shopping  Not applicable due to member's age

Are you able to complete the activities you wish to participate in with enough energy?  Yes  No

Would you like to talk with your provider about increasing your ability to engage in physical activity?

Yes  No

Have you used the emergency room 3 times or more in the last 3 months?  Yes  No

Have you been hospitalized for more than a 2-week period in the last 3 months?  Yes  No

If yes, was it for a new baby in the NICU (neonatal intensive care unit)?  Yes  No

Have you made a suicide attempt in the past 12 months?  Yes  No

Have you been released from jail or prison in the last 6 months?  Yes  No  Choose not to answer

Do you have trouble falling or staying asleep?  Yes  No

Do you have trouble staying awake during the course of a normal day?  Yes  No

Would you like a care manager to reach out to you to assist you with health concerns, community resources or other questions or issues?  Yes  No

Thank you for taking the time to answer these questions. Is there anything else you think we should know about you, your child, or family?

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