Health Risk Assessment Questionnaire

Name:
Date:

How would you rate your health in general?

- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

How have things been going for you during the past four weeks?

- ○ Very well - could hardly be better
- ○ Pretty good
- ○ Good and bad parts about equal
- ○ Pretty bad
- ○ Very bad - could hardly be worse

Has your physical and emotional health limited your social activities with family, friends, neighbors or groups?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Quite a bit
- ○ Extremely

How much difficulty have you had doing your usual activities or tasks, both inside and outside the house because of your physical and emotional health?

- ○ No difficulty at all
- ○ A little bit of difficulty
- ○ Some difficulty
- ○ Much difficulty
- ○ Could not do

Have you experienced any teeth or denture problems?

- ○ Not at all
- ○ Slightly
- ○ Moderately
- ○ Quite a bit
- ○ Last Dental Exam? _____
- ○ Name of Dentist: _____

Have you experienced any vision problems?

- ○ Not at all
- ○ Slight
- ○ Moderately
- ○ Quite a bit
- ○ Last Eye Exam? _____
- ○ Name of Eye Specialist: _____

Do you go to any specialist?

- ○ Yes, routinely
- ○ Sometimes
- ○ No
- ○ Names of ALL your specialist:

  _____
  _____
  _____

Do you use any medical supplies or equipment?

- ○ Yes
- ○ No
- ○ What supplies/equipment do you use?

  _____
- ○ Name of companies you use for the above:

  _____

Do you live alone?

- ○ Yes
- ○ No

In your home, do you have the following? Check all that apply.

- ○ Smoke detectors
- ○ Carbon monoxide detectors
- ○ Grab bars in bathroom
- ○ Stairs/steps
- ○ Throw rugs

During the past 7 days, how much pain have you experienced?

- ○ None
- ○ Some
- ○ Alot

Have you had little interest or pleasure in doing things?

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

Have you felt down, depressed, or hopeless?

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

Can you bathe yourself completely or only needs help with a single body part?

- Yes
- No

Do you get your own clothes from closet and drawers and put them on without assistance?

- Yes
- No

Are you able to go to toilet, get on and off, arrange clothes, and clean genital area without help?

- Yes
- No

Are you able to move in and out of bed or a chair unassisted?

- Yes
- No

Do you have complete self control over urination and defecation?

- Yes
- No

Are you able to get food from plate into mouth without help?

- Yes
- No

Do you wear hearing aids daily?

- Yes
- Sometimes
- No

Do you have difficulty hearing when someone speaks in a whisper?

- Yes
- Sometimes
- No

Do you have difficulty when listening to the TV?

- Yes
- Sometimes
- No

Do you have a living will?

- Yes
- No

Do you have a Health Care Power of Attorney?

- Yes
- No
- If yes, name of HCPOA _____

Have you fallen 2 or more times in the past year?

- Yes
- No

Are you afraid of falling?

- Yes
- No

Do you exercise for about 20 minutes 3 or more days a week?

- Yes, most of the time
- Yes, some of the time
- No, I usually do not exercise this much.

During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?

- Very heavy
- Heavy
- Moderate
- Light
- Very light

Can you do your housework without help?

- Yes
- No

Can you handle your own money without help?

- Yes
- No

Are you able to do your own grocery shopping without help?

- Yes
- No

Are you having difficulties driving your car?

- Yes, often
- Sometimes
- No
- Not applicable, I do not use a car

Do you fasten your seat belt when you are in a car?

- Yes, almost always
- Yes, sometimes
- No

How often do you eat food that is healthy (such as fresh fruits, fish and vegetables) instead of unhealthy food (such as fried foods, sweets and "junk food")?

- Almost always healthy meals
- Most of the time healthy meals
- Some of the time healthy meals
- A little of the time healthy meals
- Almost never healthy meals

How often do you have trouble taking medicines the way you have been told to take them?

- I do not have to take medicines
- I always take them as prescribed
- Sometimes I take them as prescribed
- I seldom take them as prescribed

How confident are you that you can control and manage most of your health problems?

- Very confident
- Somewhat confident
- Not very confident
- I do not have any health problems.

Do you have enough money to buy the things that you need to live everyday such as food, clothing, or housing?

- Yes, always
- Sometimes
- No

During the past 4 weeks, how often have problems in your household led to: Insult? Threat? Yelling? Hitting or pushing?

- None of the time
- A little of the time
- Some of the time
- Most of the time
- All of the time

In the past year did you stay in a hospital overnight or longer?

- Yes
- No

Are you a smoker?

- No, I have never smoked
- No, but I have been exposed to second hand smoke
- No, but I used to smoke.
  When did you quit?_____
- Yes, and I might quit
- Yes, but I'm not ready to quit

In the past year, did you have a drink containing alcohol?

- Yes
- No

If yes to above, how often did you have a drink containing alcohol in the past year?

- Monthly or less
- Two to four times a month
- Two to three times a week
- Four or more times a week

If yes to above, how many drinks did you have on a typical day when you were drinking?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

If yes to above, how often did you have six or more drinks on one occasion in the past year?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

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

- 8th grade or less
- Some high school, but did not graduate
- High school graduate or GED
- Some college or 2-year degree
- 4-year college graduate
- More than 4-year college degree