Medicare AWV Health Risk Assessment

Date: Crt Date
Name: Pat Whole Name (First Name First) **DOB:** Pat DOB

Please answer all of the questions below.
This questionnaire will help us develop a health care plan designed for your needs.

What is your primary language spoken at home?
☐ English
☐ Spanish
☐ Other (specify):

How do you prefer we communicate with you?
☐ Phone
☐ Text
☐ Email

How is your overall health?
☐ Excellent
☐ Good
☐ Fair
☐ Poor

What are your biggest concerns about managing your health?
☐ None
☐ I live in an unsafe environment
☐ Transportation to appointments
☐ Financial difficulty in paying for services/medicines
☐ Difficulty reading or understanding instructions
☐ I am lonely or don't have a lot of support at home
☐ I fall a lot at home

How many times in the last 6 months have you been to the **Emergency Room**?
☐ 0
☐ 1-2 times
☐ 3-4 times
☐ 5+ times
☐ I do not know

How many times in the last 6 months have you been **admitted to the Hospital**?
☐ 0
☐ 1-2 times
☐ 3-4 times
☐ 5+ times
☐ I do not know

ADLs (Activities of Daily Living)

Which of the following can you do on your own without help?
☐ Bath
☐ Dress
☐ Eat
☐ Walk
☐ Transfer in/out of chair, etc.
☐ Use the restroom
☐ None

IADLs (Independent Activities of Daily Living)

Which of the following can you do on your own without help?

☐ Shop for groceries
☐ Use the telephone
☐ Housework
☐ Handle finances
☐ Make meals
☐ Take medications
☐ None

Does someone help you at home?

☐ No
☐ Yes
☐ Spouse
☐ Children
☐ Aide/Caregiver
☐ Other:

Many people experience leakage of urine, also called urinary incontinence. In the past 6 months, have you experienced leaking of urine?

☐ No
☐ Yes
☐ When I cough or sneeze
☐ I do not know

Please list any **new medications** you have started since your last visit with us:

Please list any updates to your **Family Medical History** (family conditions that your doctor may not know about):

Have you had any problems with your **Vision**?

☐ No
☐ Yes
If yes, explain:

Have you had any problems with your **Hearing**?

☐ No
☐ Yes
If yes, explain:

Do you or your family members have any concerns about your memory?

☐ No
☐ Yes
If yes, explain:

Tobacco Use - Do you use any tobacco products?

☐ No
☐ Former Smoker
☐ Yes, current smoker
Years:
Packs per Day:

Fall Risk Screening

Which of these assistive devices do you use?
☐ Cane
☐ Walker
☐ Wheelchair
☐ Crutches
☐ None
☐ Other:

Do you have trouble with your balance?
☐ No
☐ Yes
If yes, explain:

Have you fallen 2 or more times or have had a fall with injury in the past year?
☐ No
☐ Yes
If yes, explain:

Are you afraid of falling?
☐ No
☐ Yes
If yes, explain:

Patient Health Questionnaire (PHQ-2)

Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things:
☐ Not at all
☐ Several Days
☐ More than half the Days
☐ Nearly Every Day

Feeling down, depressed or hopeless:
☐ Not at all
☐ Several Days
☐ More than half the Days
☐ Nearly Every Day

Preventative Services

Last Mammogram/Breast Cancer Screening
Date:
Result:

Last Colonoscopy/Colon Cancer Screening
Date:
Result:

Last Influenza Vaccine:
Date:

Pneumococcal Vaccine:
Date:

Advance Directives

Does your family or friends know what you want in an emergency situation or if you could not speak for yourself?

☐ Yes, I have a Living Will
☐ Yes, I have a Power of Attorney
☐ Yes, I have completed 5 Wishes
☐ No

Patient Care Team

Please list any new healthcare providers you have seen since your last visit with us:

PATIENT HEALTH QUESTIONNAIRE-9 (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**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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**
☐	☐	☐	☐

Genesee Community Health Innovation Region Health Needs Screening Tool

Name: _____ Today's Date: _____

Address: _____ Phone Number: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Physician / Provider: _____ Race / Ethnicity: _____

Preferred Language: _____ Health Insurance: [ ] Medicaid [ ] Commercial [ ] Medicare

If "Commercial", name of Insurance Company: _____

		YES / NO	
	In the last 12 months, did you ever **eat less than you felt you should** because there wasn't enough money for food?	Y	N
	In the last 12 months, has your **utility company shut off your service** for not paying your bills?	Y	N
	Are you worried that in the next 2 months, you **may not have stable housing?**	Y	N
	Do problems getting **child care make it difficult for you to work** or study? (*leave blank if you do not have children*)	Y	N
	In the last 12 months, have you **needed to see a doctor, but could not** because of cost?	Y	N
	In the last 12 months, has **lack of transportation** kept you from medical appointments? Has it kept you from meetings, work or getting things needed for daily living?	Y Y	N N
	Do you ever need help **reading information from your doctor?**	Y	N
	Are you **afraid you might be hurt** in your apartment building or house?	Y	N
	Are you interested in information on **alcohol and/or drug misuse** (including prescription drugs)?	Y	N
	Have you **felt sad or depressed** much of the time in the past year?	Y	N
	Do you need help with **access to clean water, or have you used Flint water** since April 2014?	Y	N
	Are you **unemployed and actively looking** for a job but cannot find one?	Y	N
	Do you want **help with school or job training**, like finishing a GED, going to college, or learning a trade?	Y	N
	If you checked YES to any of the boxes above, **would you like to receive assistance** with any of these needs?	Y	N
	**Are any of your needs urgent?** For example: I don't have food tonight, I don't have a place to sleep tonight.	Y	N

-- Declined to answer screen.

This screening tool has been sourced from materials provided by Health Leads.

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