

Patient Name: _____ DOB: _____ Date: _____

Health Risk Assessment (HRA)

Please circle the answers to each question below. Please complete and sign every page.

Self- assessment of Health Status, Frailty and Physical Functioning (ADLs & IADLs)				
1. How does your health compare to most people your age?	Great	Good	Fair	Poor
2. Do you have trouble dressing, bathing, eating, using the toilet or grooming?			No	Yes
3. Do you have trouble doing errands alone such as visiting your doctor or shopping?			No	Yes
4. Do you have trouble making food, doing housework, using phone or transportation?			No	Yes
5. Do you have trouble using your checkbook, paying bills or taking medicine?			No	Yes
6. Do you leak urine or soil your under clothes?			No	Yes
7. Do you have serious difficulty walking or climbing stairs?			No	Yes
8. Have you tripped or fallen during the last year?			No	Yes
9. Do you have trouble keeping your balance?			No	Yes
10. Are you deaf or do you have serious trouble hearing?			No	Yes
11. Are you legally blind or do you have serious trouble seeing, even if you wear glasses?			No	Yes
12. Do you exercise on a regular basis?			No	Yes
Psychosocial Risks				
13. Have you felt depressed, down, or hopeless in the last 14 days?			No	Yes
14. Have you lost pleasure in doing things you enjoy in the last 14 days?			No	Yes
15. Are you a victim of physical, sexual or emotional abuse?			No	Yes
16. Have you felt unusual pain or fatigue in the last 14 days?			No	Yes
17. Have you felt unusual stress, anger or loneliness in the last 14 days?			No	Yes
18. If you live with someone, is that person in good health?			No	Yes
19. Whom do you live with?	Spouse/ Partner	Assisted/ Group Living	Friend/ Family	Alone

Behavioral Risks (Social, Nutrition, & Safety)			
20. Do you drink alcohol, use tobacco or take illicit drugs?	No	Yes	
21. Are you sexually active?	No	Yes	
22. Do you frequently use sugar, salt or eat fatty or fried foods?	No	Yes	
23. Do you frequently eat fruits, vegetables, fiber and whole grains?	No	Yes	
24. Do you take calcium or vitamin supplements?	No	Yes	
25. Have you seen a dentist during the last year?	No	Yes	
26. Do you use a seat belt when riding in a vehicle?	No	Yes	
27. Do you have any safety concerns at home?	No	Yes	
Cognitive Impairment			
28. Are you or is someone close to you concerned about your memory?	No	Yes	
29. Do you have trouble concentrating, remembering things or making decisions?	No	Yes	
Providers & Suppliers			
30. Do you have other providers that give you care on a regular basis?	No	Yes	
31. Does anyone else give you medical supplies on a regular basis?	No	Yes	
32. Do you have a medical power of attorney/ advanced directive?	No	Don't Know	Yes

****Please sign ****

Patient Signature

Date

Medical Staff (Clinical Support or Provider)

Date

Patient Name: _____

DOB: _____

Please list all current physicians and specialty involved in your health care management:

Physician's Name	Specialty of Care

Please list all current medical supplies (i.e. respiratory aids, diabetes supplies, etc.):

Medical Supplies	Supplier	Supplier Contact Number

****Please sign even if above lists are blank****

Patient Signature

Date

Provider Signature

Date