PeakHealth

Health Risk Assessment Questionnaire

Enrollee Information:

Last	First	Middle

Gender:	Primary Language:	Phone Number:
Female ☐ Male ☐ Intersex ☐ Transexual ☐ Non-Conforming ☐ Personal ☐ Eunuch ☐ Prefer not to answer ☐ Other ☐	English ☐ Spanish ☐ Prefer Not to Say ☐ Other ☐	

Ethnicity:

☐ White or Caucasian ☐ Black or African American ☐ Hispanic/Latino
☐ Native American/Alaskan Native ☐ Asian ☐ Pacific Islander/Native Hawaiian
☐ Unknown ☐ Other ☐ I prefer not to answer

Best Time to Call:

☐ Early Morning: 8 AM – 10 AM ☐ Late Afternoon: 4 PM-6 PM ☐ Late Morning: 10 AM-12 PM
☐ Evening: 6 PM-8 PM ☐ Lunch Time: 12 PM-2 PM ☐ Mid-Afternoon: 2 PM-4 PM
☐ I can be contacted any time

Height and Weight:

_____ Ft _____ Inches
_____ pounds

Housing:

☐ Private Home ☐ Assisted Living ☐ Nursing Home ☐ Group home ☐ Apartment
☐ Condominium ☐ Halfway house ☐ Trailer/mobile home ☐ Homeless ☐ Other

How would you rate your overall health:

☐ Good
☐ Fair
☐ Poor

How much do you need help with the following: (No Help, Some Help; Can't do at all)

Bathing _____ Dressing _____ Eating _____ Getting Out of Bed or Chair _____
Preparing Meals _____ Taking Medications _____ Using the Bathroom _____

If you do need help, do you have someone close by or a caregiver who helps you?

☐ Family ☐ Friend ☐ Neighbor ☐ Caregiver ☐ No Help ☐ Other

Do you use any medical equipment?

☐ Walker ☐ Wheelchair ☐ Hospital bed
☐ Oxygen ☐ Nebulizer ☐ Portable toilet
☐ Shower Chair ☐ CPAP/BiPAP ☐ Other

Is there anything preventing you from taking steps to get you the care that you need?

☐ Transportation ☐ Cost of medical services ☐ Cost of Medications ☐ Access to services needed ☐ Caregiver support
☐ Language differences ☐ Hard of hearing ☐ Visual difficulties ☐ Family objections ☐ Social issue: discrimination/distrust
☐ Mental Health ☐ Domestic Violence ☐ Elder abuse ☐ Cultural Differences ☐ Other

What is the name of your Primary Care Provider? When did you last see your PCP? (referral to CM if more than 2 years)	Do you need help finding a PCP? ☐ Yes ☐ No Would you like a Case Manager to reach out to you? ☐ Yes ☐ No

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Health Questionnaire:					
Do you have any of the following health conditions? Please answer Yes or No.					
Asthma	☐ Yes	☐ No	COPD	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Coronary Heart Disease	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No	Frequent Chest Pains	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No	Frequent Falls	☐ Yes	☐ No
Kidney Failure (ESRD)	☐ Yes	☐ No	Parkinson's	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No	Cerebral Palsy	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Dementia/Alzheimer's	☐ Yes	☐ No
Memory Loss	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Vision Loss	☐ Yes	☐ No
Back Injuries	☐ Yes	☐ No	Hearing Loss	☐ Yes	☐ No
Quadriplegic	☐ Yes	☐ No	Paraplegic	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Organ Transplant	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Have you ever had a heart attack?				☐ Yes	☐ No
Have you ever had a stroke?				☐ Yes	☐ No
Do you use nicotine products? (smoking, vaping, chew, etc.)				☐ Yes	☐ No
Do you receive the flu vaccine annually?				☐ Yes	☐ No
Have you received a COVID-19 vaccine in the past year?				☐ Yes	☐ No
(FEMALES ONLY) Have you had a mammogram in the last two years?				☐ Yes	☐ o
Do you have an advanced healthcare directive?				☐ Yes	☐ No
When was your last colon cancer screening?				**Date:** _____	

Please answer the following questions.				
In an average week, how many alcoholic beverages do you drink? ***A 12 oz. bottle or can of beer, a glass of wine, wine cooler, shot of liquor or mixed drink is considered one drink.***	☐ I do not drink	☐ 1-7	☐ 8-14	☐ 15+
Do you take medications as prescribed by your doctor?	☐ I do not take medications	☐ Always	☐ Sometimes	☐ Never
How many medications are you prescribed? ***Not over the counter medications***	☐ 0	☐ 1-4	☐ 5-9	☐ 10+
In the last 6 months, how many times did you go to the emergency room?	☐ 0	☐ 1	☐ 2	☐ 3+
In the last 6 months, how many times were you admitted into the hospital?	☐ 0	☐ 1	☐ 2	☐ 3+

Over the past two weeks, have you had any of the following feelings?				
Feeling down, depressed, or hopeless	☐ Not at all	☐ Several Days	☐ More than half days	☐ Nearly every day
Little interest or pleasure in doing things	☐ Not t all	☐ Several Days	☐ More than half days	☐ Nearly every day
Crying Spells	☐ Not at all	☐ Several Days	☐ More than half days	☐ Nearly every day
Difficulty Sleeping	☐ Not at all	☐ Several Days	☐ More than half days	☐ Nearly every day
Nervousness, anxiety, worriedness	☐ Not at all	☐ Several Days	☐ More than half days	☐ Nearly every day
Agitated, irritable, angry	☐ Not at all	☐ Several Days	☐ More than half days	☐ Nearly every day
Stressed	☐ Not at all	☐ Several Days	☐ More than half days	☐ Nearly every day
Thoughts of hurting yourself or others	☐ Not at all	☐ Several Days	☐ More than half days	☐ Nearly every day

Do you have any of the following stressors? Please answer Yes or No		
Relationships	☐ Yes	☐ No
Family	☐ Yes	☐ No
Children	☐ Yes	☐ No
Lack of social support	☐ Yes	☐ No
Occupation	☐ Yes	☐ No
General Physical Health	☐ Yes	☐ No
Financial	☐ Yes	☐ No
Other: _____	☐ Yes	☐ No
No stressors at this time	☐ Yes	☐ No

If you would like more information about our Care Management programs, please contact us at [1-855-962-7325 Monday though Friday from 8:00am – 5:00pm].

As a member of Peak Advantage, you also have 24/7 access to a registered nurse for medical advice at [1-844-484-0307].