

Medicare DSNP Health Risk Assessment Questionnaire

Please fill in all boxes completely or with an X.   Do NOT checkmark.

Enrollee Information				
Name:				
Date of Birth:			Date of Completion:	
Gender:	☐ Female	☐ Male	☐ Other	☐ Prefer not to answer
Preferred Language:	☐ English		☐ Spanish	☐ Other
Ethnicity: ☐ White or Caucasian ☐ Black or African American ☐ Pacific Islander/Native Hawaiian ☐ Native American/Alaskan Native ☐ Asian ☐ Other ☐ Unknown ☐ Hispanic/Latino ☐ I prefer not to answer				
Preferred Method of Contact:			☐ Phone	☐ MyChart
How would you rate your overall health:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
How much do you need help with the following:				
Bathing	☐ No help	☐ Some help	☐ Can't do at all	
Eating	☐ No help	☐ Some help	☐ Can't do at all	
Preparing meals	☐ No help	☐ Some help	☐ Can't do at all	
Using the bathroom	☐ No help	☐ Some help	☐ Can't do at all	
Dressing	☐ No help	☐ Some help	☐ Can't do at all	
Getting out of bed or chair	☐ No help	☐ Some help	☐ Can't do at all	
Taking medications	☐ No help	☐ Some help	☐ Can't do at all	
Walking	☐ No help	☐ Some help	☐ Can't do at all	
If you need help with any of the above, do you have someone close by or a caregiver who helps you? ☐ Family ☐ Friend ☐ Neighbor ☐ Caregiver ☐ No Help Needed ☐ No Support ☐ Other				

Do you need help finding a Primary Care Physician:			☐ Yes	☐ No	
Do you need help finding a mental health specialist:			☐ Yes	☐ No	
What is your housing situation today: ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) ☐ I have housing today, but I am worried about losing housing in the future. ☐ I have housing					
Within the past 12 months, were you worried that your food would run out before you got money to buy more? ☐ Often true ☐ Sometimes true ☐ Never true					
Within the past 12 months, the food you bought just didn't last and you didn't have money to get more? ☐ Often true ☐ Sometimes true ☐ Never true					
In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or getting things needed for daily living? (check all that apply) ☐ Yes, it has kept me from medical appointments or getting medications. ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need. ☐ No					
In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home? ☐ Yes ☐ No ☐ Already shut off					
How often does anyone, including family, threaten you with harm or physically hurt you? ☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently					
Do you have dependable internet? (Your internet works well, and stays connected)			☐ Yes	☐ No	
Do you have a smartphone or a computer with a camera and a microphone?			☐ Yes	☐ No	
Can you download a mobile application or "app" and change browser or camera settings on a computer or smartphone?			☐ Yes	☐ No	
Would you like assistance or resources to learn more about scheduling telemedicine/virtual visits?			☐ Yes	☐ No	
Have you ever been diagnosed by a provider with any of the following?					
Shortness of Breath	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Heart Failure	☐ Yes	☐ No	COPD/Lung Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Frequent Falls	☐ Yes	☐ No

Kidney Disease	☐ Yes	☐ No	Parkinson's	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No	Dementia/Alzheimer's	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No	Vision Loss	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Hearing Loss	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Transplant	☐ Yes	☐ No
Quadriplegic/Paraplegic	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Amputee	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Non-healing wounds	☐ Yes	☐ No
Over the past two weeks, have you been bothered by little interest or pleasure in doing things several days or more?				☐ Yes	☐ No
Over the past two weeks, have you been bothered by feeling down, depressed, or hopeless several days or more?				☐ Yes	☐ No
How often do you feel lonely?		☐ Seldom or Never	☐ Some of the time	☐ Often	
Do any of the following apply to you? Please mark all that apply. ☐ I feel my weight is too high ☐ I don't get enough physical activity ☐ I drink too much alcohol ☐ I feel my weight is too low ☐ I smoke or use tobacco ☐ I use drugs or medications not prescribed to me ☐ I don't eat a healthy diet ☐ I have trouble handling my stress ☐ None of these apply to me					
Do you experience any of the following? Please mark all that apply. ☐ I forget information recently learned ☐ I struggle to remember words, dates, or events ☐ I ask for the same information multiple times or need reminder notes ☐ I lose or misplace things often ☐ I have trouble following directions ☐ My family/friends say I am forgetful ☐ I become confused or distracted in the middle of a conversation ☐ None of these apply					
Do you take your medications as prescribed? Please mark all that apply. ☐ I do not take any medications ☐ I have trouble getting my medications ☐ I take all my medications as prescribed ☐ I have trouble remembering to take my medications ☐ I do not take all my medications as prescribed ☐ I don't know if I am taking my medications as prescribed ☐ I have trouble paying for my medications					
How many medications are you currently prescribed? ☐ 0 ☐ 1-4 ☐ 5-9 ☐ More than 10					
In the last 12 months, how many times have you been to the emergency room? ☐ 0 ☐ 1 ☐ 2 ☐ More than 3					

In the last 12 months, how many times have you been admitted to the hospital? ☐ 0 ☐ 1 ☐ 2 ☐ More than 3		
Are you the primary caregiver for someone else? ☐ Yes, and I have no concerns caring for someone else ☐ Yes, and caring for someone else impacts my own health and wellness ☐ No, I am not the primary caregiver for someone else		
Have you fallen 2 or more times in the last 3 months?	☐ Yes	☐ No
Do you have an advanced healthcare directive?	☐ Yes	☐ No
Do you receive the flu vaccine annually?	☐ Yes	☐ No
Do you have assistive devices or other equipment to manage daily living? Please mark all that apply. ☐ Cane ☐ Motorized scooter ☐ Lift assistance ☐ Oxygen ☐ Ventilator ☐ Walker ☐ Prosthetic ☐ Glucometer ☐ CPAP or BiPAP ☐ Other ☐ Wheelchair ☐ Hospital bed ☐ Nebulizer		

If you would like more information about our Care Management programs, please contact us at 1-855-962-7325 Monday through Friday from 8:00 am – 5:00 pm. As a member of Peak Medicare, you also have 24/7 access to a registered nurse for medical advice at 1-844-484-0307.