HealthPartners

Inspire (SNBC) HEALTH RISK ASSESSMENT

Today's Date:

Last Name:		**First Name:**		**MI:**	

HP ID #:		**Primary Clinic Name:**	
Primary Language:		**Primary Clinic Phone #:**	
Interpreter Needed?	☐ Yes ☐ No	**Primary Doctor's Name:**	
Ethnicity:		**Marital Status:** ☐ 01 – Single, never married ☐ 02 – Divorced ☐ 03 – Widowed ☐ 04 – Married ☐ 05 – Legally Separated ☐ 99 – Unknown	
Date of Birth:			
Address:		**Emergency Contact Name(s) Phone:**	
		If applicable, Legal Guardian or Conservator's name & phone#:	
Home Phone#:	**Cell Phone #:**		

Current Waiver Type:
- ☐ CAC
- ☐ CADI
- ☐ BI (Formerly TBI)
- ☐ DD
- ☐ Not Currently on waiver

What is the nature of your disability?
- ☐ Developmental
- ☐ Physical Health
- ☐ BI Mental Health
- ☐ Unsure

What is your current Living Arrangement?
- ☐ 01 – Living Alone
- ☐ 02 – Living with spouse/parent
- ☐ 03 – Living with family, friends, significant other
- ☐ 04 – Living in congregate setting
- ☐ 05 - Homeless

What is your current housing type?
- ☐ 01 – Homeless
- ☐ 02 – Institution ICF/DD
- ☐ 03 – Institution Hospital
- ☐ 04 – Board and Lodge
- ☐ 05 – Foster Care
- ☐ 09 – Own Home, Apt.
- ☐ 11 – Institution, NF/Certified boarding care
- ☐ 12 – Non certified boarding care
- ☐ 16 – Correctional Facility

Does your housing meet your needs?	☐ Yes ☐ No	**If no, how can we assist?**	
Are you currently working?	☐ Yes ☐ No	**If yes, describe**	
Are you currently in School?	☐ Yes ☐ No	**If in school, do you have in Individualized Education Plan (IEP) in place?**	☐ Yes ☐ No

Physical Health Conditions

Check all that apply.

- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Amputation
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD or Chronic Bronchitis
- ☐ Other Breathing Problems
- ☐ Diabetes
- ☐ Developmental Disorder
- ☐ Nausea/Vomiting
- ☐ Asperger's Syndrome
- ☐ Ankle/Leg Swelling
- ☐ High Blood Pressure
- ☐ History of Heart Attack
- ☐ Heart Failure (congestive)
- ☐ Angina / chest pain
- ☐ Anemia
- ☐ Stroke / CVA
- ☐ HIV or AIDS
- ☐ Stomach Ulcers
- ☐ Cerebral Palsy
- ☐ Down Syndrome
- ☐ Multiple Sclerosis
- ☐ Brain Injury
- ☐ Paralysis
- ☐ Seizures
- ☐ Parkinson's syndrome
- ☐ Urinary Problems
- ☐ Dialysis
- ☐ Constipation
- ☐ Hepatitis
- ☐ Autism
- ☐ Other

Are you diabetic? ☐ Yes ☐ No		**If yes, How do you control your diabetes?**	☐ Oral Meds ☐ Diet ☐ Insulin
Do you have cancer? ☐ Yes ☐ No		**If yes, list type:**	**Are you receiving Chemotherapy?** ☐ Yes ☐ No
Are you pregnant ☐ Yes ☐ No		**How many weeks?**	**Are you seeing a doctor for your pregnancy?** ☐ Yes ☐ No
Are you dependent on a ventilator to help you breathe? ☐ Yes ☐ No		**Please Indicate any special treatments you receive:** ☐ None ☐ Tube Feedings ☐ Intravenous Fluids ☐ Intravenous medications ☐ Wound Care ☐ One or more of the following: Catheter or ostomy care, blood transfusions, respiratory therapy	
If you have pain, is the pain: ☐ controlled ☐ not controlled ☐ no pain		**If you have pain, please rate it between 0-10, with 0 being no pain and 10 being the most pain**	
What causes you pain?		**Would you like assistance with pain management?** ☐ Yes ☐ No	
What is last your blood pressure?		**When was your blood pressure last checked?**	

Have you had any falls in the past year? ☐ Yes ☐ Yes, with a fracture ☐ No ☐ No, but have balance issues	**Do you have any problems with orientation or memory?**	☐ Yes ☐ No
	If yes, indicate:	☐ Minor forgetfulness ☐ Sometimes disoriented ☐ Always disoriented ☐ Unsure
Are you able to communicate your needs? ☐ Yes ☐ Yes with difficulty ☐ Yes through nonverbal means ☐ No	**In the past 6 months, have you lost more than 10 pounds without trying?**	☐ Yes ☐ No

Vision

- ☐ 00 – No vision impairment
- ☐ 01 – Has difficulty seeing at level of print
- ☐ 02 – Has difficulty seeing obstacles in environment
- ☐ 03 – Has no useful vision
- ☐ 04 – Not determined

Hearing

- ☐ 00 – No hearing impairment
- ☐ 01 – Has difficulty at level of convention
- ☐ 02 – Hears only very loud sounds
- ☐ 03 – No useful hearing
- ☐ 04 – Not determined

Other Notes:

PREVENTIVE CARE:

Please check all services you have received and last date completed if known:

☐ Flu Vaccine		☐ Pneumonia Vaccine		☐ Tetanus Vaccine	
☐ Shingles Vaccine		☐ Mammogram		☐ Colonoscopy	
☐ Annual Physical		☐ HPV		☐ Hearing Exam	
☐ Vision Exam		☐ Dental Exam		☐ PAP Smear	

Physical Health Rating:

Overall, how would you rate your physical health?

☐ 04 – Excellent ☐ 03 – Good ☐ 02 – Fair ☐ 01 – Poor ☐ 00 – No Response

Mental Health Conditions

Have you ever been diagnosed with, or have a history of Mental Illness?	☐ Yes ☐ No		
If yes, check all that apply: ☐ Depressive Disorder ☐ Bipolar Disorder ☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Anxiety Disorder ☐ Borderline Personality Disorder ☐ Chemical Dependency ☐ Other (describe)		Does your mental health cause behaviors that interfere with your daily activities?	☐ Yes ☐ No
		If yes, does anyone help you by providing cues or redirection?	☐ Yes ☐ No
		Do you typically accept redirection when provided?	☐ Yes ☐ No
Have you or are you seeing a mental health specialist (Psychiatrist, Psychologist, Therapist, etc	☐ Yes ☐ No	If yes, What is the specialist name/Contact info:	
Do you have a Targeted Mental Health Case Manager (TCM)?	☐ Yes ☐ No	If yes, name and contact number of TCM:	
Do you have anyone else that helps you with your mental health needs including an ARMHS or ACT worker?	☐ Yes ☐ No	If yes, name and contact number:	
Have you ever been hospitalized for depression?	☐ Yes ☐ No	If yes, How many times in the past year?	

During the past month, how often have you been bothered by feeling down, depressed or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

Over the last four weeks, how often have you been bothered by having little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly everyday

Do you have severe stressors in your life?	☐ Yes ☐ No	If yes, please describe:
Do you wish you had more social supports?	☐ Yes ☐ No	If yes, please describe:

Mental Health Rating:

Overall, how would you rate your mental/emotional health?

☐ 04 – Excellent ☐ 03 – Good ☐ 02 – Fair ☐ 01 – Poor ☐ 00 – No Response

Other Notes:

Substance Use/Chemical Health			
Are you currently using any mood altering substances such as alcohol or recreational drugs?	☐ Yes ☐ No *If no skip to MEDICATIONS section below. If yes, Continue.		
Please indicate any substances you're using: ☐ Alcohol ☐ Marijuana ☐ Heroin ☐ Methamphetamine ☐ Cocaine ☐ other (describe)			
How often do you use them?			
Do you have any chemical health diagnoses or concerns?	☐ Yes ☐ No	If yes, please describe:	
Have you been to Detox, Chemical Dependency Treatment, or a Hospital for substance abuse or withdrawal?	☐ Yes ☐ No	If yes, when, and for what reason?	
If you drink Alcohol, have you ever felt a need to cut down on drinking?	☐ Yes ☐ No	Have you ever felt bad or guilty about your drinking?	☐ Yes ☐ No
Have you ever drank first thing in the morning to steady your nerves and/or get rid of a hangover?	☐ Yes ☐ No	Have you ever been annoyed by other people's concerns about your drinking?	☐ Yes ☐ No
Do you smoke?	☐ Yes ☐ No	If yes, how much?	
Medications			
Do you have any challenges with taking your medications?	☐ Yes ☐ No	If yes, please describe assistance you receive or want, if any, to help manage your medications:	

Medication	*Dosage*	*Currently Taking?*

Other Notes:

Other Information			
In the past year, how many times did you visit a physician or clinic? ☐ Not at all ☐ 1 Time ☐ 2-3 Times ☐ 4-6 Times ☐ More Than 6 Times			
In the past year have you been to the hospital emergency room for any reason?	☐ Yes ☐ No	If yes, list how many times and reason?	
In the past year have you stayed overnight or longer in a hospital?	☐ Yes ☐ No	If yes, list how many times and reason?	
In the past year, have you stayed overnight or longer in a rehabilitation facility?	☐ Yes ☐ No	If yes, list how many times and reason?	
In the past year have you spent any time in a nursing home?	☐ Yes ☐ No	If yes, list how many times and reason?	
Home and Safety Preservation			
Are you able to cope, make appropriate decisions, and take action in a changing environment or a potentially harmful situation?	☐ Yes ☐ No	If no, Is someone available to help you?	☐ Yes ☐ No
If no, please explain your circumstances:			
How much help would you need to get out safely if there were a fire or other emergency? ☐ None ☐ Some assistance ☐ Much assistance ☐ Total assistance		If needed, do you have help?	☐ Yes ☐ No
Are you concerned with someone hurting you emotionally, physically, or taking advantage of you financially?	☐ Yes ☐ No ☐ In the past, not currently		
Health Care Directive			
Do you have a written Advance Medical Directive?	☐ Yes ☐ No	If no, would you like information about an Advance Directive?	☐ Yes ☐ No ☐ Information given/Referral made
Other Notes:			

Home Management Tasks

How well are you able to use the telephone? Would you say that you:		
Use the telephone ☐ 01 – Need no help or supervision ☐ 02 – Need some help or occasional supervision ☐ 03 – Need a lot of help or constant supervision ☐ 04 - Can't do it at all	**Make telephone calls** ☐ 01 – Need no help or supervision ☐ 02 – Need some help or occasional supervision ☐ 03 – Need a lot of help or constant supervision ☐ 04 - Can't do it at all	Comments
How well do you manage shopping for food and other things you need: ☐ 01 – Need no help or supervision ☐ 02 – Need some help or occasional supervision ☐ 03 – Need a lot of help or constant supervision ☐ 04 - Can't do it at all		Comments

How well are you able to prepare meals (sandwiches, cooked meals, TV dinners) for yourself? ☐ 01 – Need no help or supervision ☐ 02 – Need some help or occasional supervision ☐ 03 – Need a lot of help or constant supervision ☐ 04 - Can't do it at all	Comments
How well can you manage to do light housekeeping, like dusting or sweeping? ☐ 01 – Need no help or supervision ☐ 02 – Need some help or occasional supervision ☐ 03 – Need a lot of help or constant supervision ☐ 04 - Can't do it at all	Comments
How well can you do heavy housekeeping? Heavy housekeeping includes activities like yard work, or emptying the garbage, but not including laundry. ☐ 01 – Need no help or supervision ☐ 02 – Need some help or occasional supervision ☐ 03 – Need a lot of help or constant supervision ☐ 04 - Can't do it at all	Comments

What about your ability to do your own laundry, including putting clothes in the washer or dryer, starting and stopping the machine, and drying the clothes? ☐ 01 – Need no help or supervision ☐ 02 – Need some help or occasional supervision ☐ 03 – Need a lot of help or constant supervision ☐ 04 - Can't do it at all	Comments
What about your ability to take your own medication? ☐ 01 – Need no help or supervision ☐ 05 – Don't take medications ☐ 06 – Need medication setup only ☐ 07 – Need visual or verbal reminders only ☐ 08 – Need medication setups and reminders ☐ 09 – Need medication setups and administration	Comments
I want to know about your ability to handle your own money, like paying your bills, or balancing your checkbook. ☐ 01 – Need no help or supervision ☐ 02 – Need some help or occasional supervision ☐ 03 – Need a lot of help or constant supervision ☐ 04 - Can't do it at all	Comments
How well are you able to use public transportation or drive to places beyond walking distance? ☐ 01 – Need no help or supervision ☐ 02 – Need some help or occasional supervision ☐ 03 – Need a lot of help or constant supervision ☐ 04 - Can't do it at all	Comments

Other Notes:

Personal Care Tasks

Dressing – How well are you able to manage dressing? Laying out the clothes and putting on the clothes, including shoes, and fastening clothes. ☐ 00 – Can dress without help of any kind ☐ 01 – Need and gets minimal supervision and reminding ☐ 02* – Needs some help from another person to put on clothes ☐ 03* – Cannot dress yourself and somebody dresses you ☐ 04* – Are never dressed	Comments
Grooming – How well are you able to manage grooming activities like combing hair, washing face, shaving, and brushing teeth? ☐ 00 – Can comb hair, wash face, shave, brush teeth without help of any kind ☐ 01 – Needs and gets supervision or reminding for grooming activities ☐ 02* – Needs and gets daily help from another person ☐ 03* – Completely groomed by somebody else.	Comments

Bathing – How well can you bathe or shower yourself. Running the water, taking a bath or shower without any help, washing all parts of your body including your face and hair. ☐ 00 – Can bathe or shower without any help ☐ 01 – Needs and gets minimal supervision or reminding ☐ 02 – Needs and gets supervision only ☐ 03 – Needs and gets help getting in and out of the tub ☐ 04* – Needs and gets help washing and drying your body ☐ 05* - Cannot bathe or shower, needs complete help	Comments
Eating – How well can you manage eating by yourself? Drinking and eating without any help from anybody else, but you use special utensils and straws, cutting most foods on your own. ☐ 00 – Can eat without help of any kind ☐ 01 – Needs and gets minimal reminding or supervision ☐ 02* – Needs and gets help in cutting food, butter bread, or arranging food ☐ 03* – Needs and gets some personal help with feeding or someone needs to be sure that you don't choke. ☐ 04* – Needs to fed completely or tube feeding or IV feeding.	Comments
Bed Mobility – How well can you manage sitting up or moving around in bed? ☐ 00 – Can move in bed without any help ☐ 01 – Needs and gets help sometimes to sit up ☐ 02* – Always need and get help to sit up ☐ 03* – Always need and get help to be turned or change positions	Comments
Transferring – How well can you get in and out of a bed or chair? ☐ 00 – Can get in and out of a bed or chair without help of any kind ☐ 01 – Needs somebody to guide you but can move in and out of a bed or chair ☐ 02* – Needs one other person to help you ☐ 03* – Needs two other people or a mechanical aid to help you ☐ 04* – Never get out of a bed or chair	Comments
Walking – How well are you able to walk around, either without help or with a cane or walker but NOT a wheelchair? Does not include climbing the stairs. ☐ 00 – Walk without help of any kind ☐ 01 – Can walk with help of a cane, walker, crutch or push wheelchair ☐ 02* – Need and gets help from one person to help you walk ☐ 03* – Needs and gets help from two people to help you walk ☐ 04* – Cannot walk at all	Comments

Toileting – How well can you manage using the toilet? Adjusting clothing, getting to and on the toilet, and cleaning one's self. If reminders are needed to use the toilet this counts as some help.	Comments
☐ 00 –Can use the toilet without help, including adjustment clothing ☐ 01 – Need some help to get to and one the toilet but don't have accidents ☐ 02* – Have accidents sometimes, but not more than once a week ☐ 03* – Only have accidents at night ☐ 04* – Have accidents more than once a week ☐ 05* – Have bowel movements in your clothes more than once a week ☐ 06* – Wet your pants and have bowel movements in your clothes very often	

Do you need help finding a medical provider?	☐ Yes ☐ No	If yes, what kind of help do you need?
Do you need help finding a mental health provider?	☐ Yes ☐ No	If yes, what kind of help do you need?
Do you currently have other health or well-being concerns that were not covered in this questionnaire?	☐ Yes ☐ No	If yes, describe
What is most important to you right now related to your health?		How can HealthPartners Inspire program most help you?
Other Notes:		