





Health Risk Screening - Adult (Age 18-64)

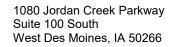
Member Information:	
Preferred Mailing Address:	
2) Preferred Phone Number: +_ ()	
3) Race (Check Whichever Applies):	
American Indian / Alaska Native	Asian
Black / African American	Native Hawaiian / Other Pacific Islander
White	Other
I prefer not to answer	Unknown
a. If you chose other, list race here:	
b. If you chose Native American: Are	you eligible to receive Indian Health Services?
Yes No	
4) Ethnicity:	
Hispanic or Latino Not Hispanic	or Latino Other
I prefer not to answer Unknown	
a. If you chose other, list ethnicity here:	
5) Language:	
English	
Other Unknown	
- If	
a. If you chose other, list preferred lang	uage nere:
6) What is your gender identity?	
6) What is your gender identity?	Non Pinary
	Non-Binary -
Transgender Prefer Not to Answer	



1080 Jordan Creek Parkway Suite 100 South West Des Moines, IA 50266



/) V	vitat is the highest level of education your	iave	completed?
	No Schooling Completed		Grade School – 8 th Grade
	Some High School, No Diploma		High School Graduate, Diploma, or GED
	Some College Credit, No Degree		Trade / Technical / Vocational School
	Associate Degree		Bachelor's Degree
	Master's Degree		Doctorate Degree or Equivalent
8) [ision, or speech requiring special services?
	a. If yes, explain:		



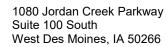






Global Health / Safety

9)	In general, how woul	d you rate your health	?	
	Excellent	Very Good	Good	
	Fair	Poor	Unknown	
	a. If you chose po	or, please explain:		
10)	On a scale of 0 – 10	, how ready are you t	make changes?	
	a. If you wrote 8,	9, or 10, tell us which	changes you'd like to make: _	
11)	Do you have a healt	h care provider?		
	Y	res No U	Inknown	
*It is	important to identify	a doctor or health car	e provider to help you stay hea	althy and in case
you	get sick			
8	a. If you answered ye	s, what is your health	care provider's name?	
k	o. Have you seen you	ır doctor or health caı	e provider in the last 12 month	ıs?
	Yes	S No Un	known	
	i. If you ar	swered yes, what did	you see your doctor for?	
	Preventative C	are	Sick Care Post Hospital	Visit
	Post Emergen	cy Room Visit	Other Visit	
	ii. If you ch	ose Other Visit, what	was the visit for?	
12)	How many times have	e you been to the ho	pital in the last 3 months?	Times
13)	How many times hav	e you been in the Em	ergency Department in the las	t 3 months?
•	How many medicines	-	ing that were prescribed by yo	our health care

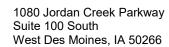








a. Does anything prevent you from taking medicine?
Yes Unknown
i. If yes, what prevents you from taking your medicine?
b. Do you ever forget to take your medicine?
Yes No Sometimes
15) When was the last time you saw your dentist?
In the last 6 months In the last 12 months More than 1 year ago*
*It is important to visit your dentist regularly. Lack of routine dental care can lead to gum disease
16) What is your height? (Enter in feet / inches) ft in.
17) What is your weight? (Enter in pounds) lbs.
18) Have you or your health care provider been concerned about your weight?
Yes (overweight) Yes (underweight) No
a. If you chose Yes (overweight), are you interested in losing weight?
Yes No Sometimes
19) Do you eat a healthy diet?
Yes No Sometimes
20) Do you participate in regular physical activity?
Yes No I am unable to exercise due to medical conditions
*Regular physical activity helps improve your overall health and fitness, and
reduces your risk for many chronic diseases. It is recommended to get at least
150 minutes of moderate exercise each week

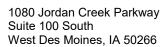








21) Have you had a flu shot in the last 12 months?
Yes No Sometimes
*Flu shots are recommended for everyone over 6 months of age every year.
Getting an annual flu shot is the best way to protect yourself and your family from the flu
22) Do you always use a seatbelt?
Yes No N/A
*Seat belt use is one of the most effective ways to save lives and reduce injuries in
crashes
23) Are you age 50 to 75?
Yes No
a. If yes, have you been screened for colon cancer since you turned 50?
Yes No N/A – History of colon cancer or colectomy
24) Are you female?
Yes No
a. If yes, how old are you?
i. Ages 18 – 20:
1. If you are sexually active now or in the past, have you had a test for
STIs like Chlamydia in the last year?
Yes No N/A – No sexual history
2. Are you pregnant?
Yes No N/A – No sexual history Unknown
a. If you are pregnant, when is the due date?//



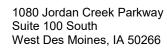




ii. Ages 21 – 24:



1. If you are sexually active now or in the past, have you had a test for STIs like Chlamydia in the last year?
Yes No N/A – No sexual history
2. Are you pregnant?
Yes No N/A – No sexual history Unknown
a. If you are pregnant, when is the due date?/
Have you had a PAP smear in the last 3 years? Yes Unknown
iii. Ages 25 – 49:
Are you pregnant? Yes No N/A – No sexual history Unknown Unknown
a. If you are pregnant, when is the due date?//
Have you had a PAP smear in the last 3 years? Yes Unknown
iv. Ages 50 – 64:
Have you had a PAP smear in the last 3 years? Yes No Unknown
2. Do you get a mammogram to check for breast cancer at least every 2
years?
Yes No Unknown



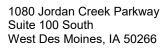






Social Concerns:

25) Do you have a job in the community?
Yes, I have a paid job Yes, I have a volunteer job
No, but I'm interested in a job No, and I'm not interested in a job
Unknown
a. If you do have a job:
i. On a scale of 0 – 10, how much did your health problems affect your
productivity while working in the past? (0 = Health had no effect, 10 = Health
had serious effects)
26) Do you currently have concerns about having enough money to pay for your basic needs?
Yes Unknown
a. If yes, please explain your concerns:
27) In the last 12 months, did you worry your food would run out before you got money to buy more?
Yes Unknown
28) In the last 12 months, did the food you bought just not last and you didn't have money to go
Yes Unknown

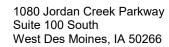








29) In the past 2 months have you been living in stable housing that you own, rent, or stay in as
part of a household?
Yes Unknown
30) Do you feel safe in your home and around all the people in your life?
Yes No Unknown
a. If no, please explain any safety concerns you have:
31) Do you have access to a safe, reliable telephone?
Yes Unknown
32) Do you ever have any problems with transportation to your medical appointments?
Yes No Unknown
33) Do you have a primary caregiver who helps you on a regular basis?
Yes Unknown
a. If yes, what relation is your caregiver to you? (Check all that apply)
Agency
Friend Other
b. What is your caregiver's name?
c. What is your caregiver's phone number? ()



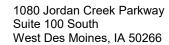






Physical Health:

34) Has a healthcare provider	ever tol	d you that you have one or m	nore of these conditions?
(Check all that apply)			
Arthritis		Asthma as an adult	Cancer
Chronic Kidney Disea	se	COPD / Emphysema	Diabetes, Type 1
Diabetes, Type 2		Pre-Diabetes	Heart Disease
Hepatitis		High Blood Pressure	High Cholesterol
HIV		Learning Disability	Sickle Cell Disease
Stroke		Transplant	
Do you have any other conditions not listed above? List them here:			
a. If you have ARTHRI	TIS: W	nat type of arthritis?	
Osteoarthritis	R	heumatoid Arthritis	Jnknown
b. If you have had a TF	RANSPI	LANT: How long ago was the	transplant?
35) On a scale of 0 – 10, how	much di	id health problems have an e	ffect on your daily activities
(other than work at a job) d	uring th	at past 7 days? (0 = Health p	roblems had no effect,
10 = Health problems preve	ented m	e from daily activity)	



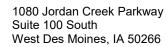






Behavioral Health:

36) In general, how satisfied are you with life	9?
Very Satisfied Satisfied	
Dissatisfied Very Dissatisfied	ed Unknown
a. If you are feeling very dissatisfied	, please explain why you are feeling that way:
37) During the past month, have you often b	peen bothered by feeling lonely?
Yes No	Unknown
38) During the past month, have you often be hopeless?	een bothered by feeling down, depressed, or
Yes No	Unknown
39) During the past month, have you been b	oothered by little interest or pleasure in doing things?
Yes No	Unknown
40) Do you feel that stress is affecting your l	health?
Yes No	Unknown
a. If yes, what are your plans for ma	naging stress?
No changes needed	No plan to change
Started making changes	Plan to change in the next month
Plan to change in next 6 months	Unknown

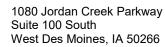








41) During the past year, now often did your	lave 5 of filore alcoholic driffks in one day?
Never Once or Twice	Monthly
Weekly Daily or Almost Daily	Unknown
*Avoiding heavy drinking is a great health ch	oice
42) During the past year, how often did you u	se tobacco products?
Never Once or Twice	Monthly
Weekly Daily or Almost Daily	Unknown
*Quitting tobacco products is the most import a. If you're currently using tobacco, we	cant thing you can do to protect your health
month?	
Yes No	Unknown
43) During the past year, how often did you u	se prescription drugs for non-medical reasons?
Never Once or Twice	Monthly
Weekly Daily or Almost Daily	Unknown
44) During the past year, how often did you u	se illegal drugs?
Never Once or Twice	Monthly
Weekly Daily or Almost Daily	Unknown
45) Do you now or have you ever had a probl	em with alcohol or substance misuse?
Yes No	Unknown

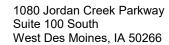








a. If yes, what type of personal misuse?
Alcohol Illegal Drugs Prescription Drugs
b. Have you received treatment for alcohol or substance use in the last 6 months?
Yes No Unknown
i. If no, would you like help getting treatment for alcohol or substance abuse
Yes No Unknown
46) Have you ever been diagnosed with a behavioral health disorder?
Yes No Unknown
a. If yes, please list the behavioral health disorder(s) you've been diagnosed with:
b. Have you been to the ER or hospitalized in the last 3 months due to a behaviora
health condition?
Yes No Unknown
c. Are you actively receiving treatment for a behavioral health disorder?
Yes No Unknown

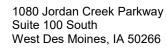








47) If you have a behavioral health disorder and are NOT receiving treatment for it, would you
like help getting treatment for a behavioral health disorder?
Yes No Unknown
48) How many hours of sleep do you usually get a night?
49) Do you have problems falling or staying asleep, or problems with sleeping too much?
Yes Unknown



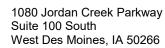






Pain / ADLS:

50) Durin	g the last month, have you had pain that interfered with completion of your housework
or you	r ability to work outside the home?
	Yes Unknown
a.	If yes, on a scale of $0 - 10$, where 0 is 'no pain' and 10 is 'the worst pain', how would
	you rate your pain at the PRESENT TIME (right now)
b.	On a scale of 0 – 10, how intense was your WOSRT pain in the last 6 months?
C.	In the past 6 months, on average, how intense was your pain on a scale of $0 - 10$?
d.	About how many days in the last 6 months have you been kept from your usual
	activities (work, school, or housework) because of pain?
	0 - 6 Days 7 – 14 Days
	15 – 30 Days 31 or More Days
e.	In the past 6 months, how much has pain interfered with your daily activities rated on a
	scale of 0 – 10, where 0 is 'no interference' and 10 is 'unable to carry on any
	activities'?
f.	In the past 6 months, how much has pain changed your ability to take part in
	recreational, social, and family activities on a scale of 0 - 10?
g.	In the past 6 months, how much has pain changed your ability to work on a scale of
	0 – 10, where 0 is 'no change' and 10 is 'extreme change'?

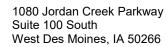








51) Do you require help with any of the following activities: Walking, getting out of a chair,
eating, bathing, dressing, or going to the bathroom?
Yes No Unknown
a. Answer this section only if you chose YES. Otherwise skip to question 52.
b. Are you able to walk safely?
Yes No Unknown
c. Are you able to get into and out of bed / a chair by yourself?
Yes No Unknown
d. Are you able to eat meals and snacks by mouth without help?
Yes No Unknown
e. Are you able to take a bath or shower by yourself?
Yes No Unknown
f. Are you able to dress yourself independently?
Yes No Unknown
g. Are you able to get to and from the toilet or bedside commode?
Yes Unknown

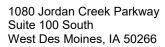








h.	Do you have complete self-control of your bowel and bladder functions?
	Yes No Unknown
i.	Who helps you with these activities now?
j.	Could you use additional help with these activities?
	Yes No Unknown



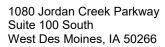






Supplemental Assessment:

52) How many family members, including yourself, do you currently work with?						
53) Wha	53) What is your housing situation?					
	I have housing and I am NOT worried about losing it in the next 6 months					
	I have housing but I AM worried about losing housing in the next 6 months					
	I do not have housing today but:					
а	. If you chose "I do not have ho	usin	g today but:", answer the following question.			
	i. I am:					
	Staying with others	Sta	aying in a hotel			
	Staying in a shelter	Liv	ring outside or in a car			
		<u> </u>				
54) How difficult is it for you to understand information that doctors, nurses, and other health						
profe	essionals tell you?					
	Very Easy Sor	newl	hat Easy			
	Somewhat Difficult Ver	y Dif	ficult			
55) What is your current work situation?						
	Unemployed		Part-Time or Temporary Work			
	Full-Time Work		Otherwise unemployed but not seeking work			

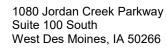








56) In the past year, ha	ave you or any	family members	you live wit	h been unable to get any of the		
following when it was really needed? Check all that apply:						
Food		Clothing		Dental Care		
Mental Health	Care	Utilities		Eye-Care		
Child Care		Phone		Medical Care		
Transportation	1	_				
57) If you have trouble	getting transp	portation when you	need it, w	hat is the MAIN reason you		
cannot get to where	e you want to ເ	go?				
I do not have	trouble getting	transportation	Car b	roke down		
Person who usually takes me is unavailab			Costs	Costs too much		
I do not have a personal vehicle			Trans	Transit system unavailable		
58) Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their						
mind is troubled. How stressed are you?						
Not at all	Somew	/hat				
A little bit Quite a bit						
Very much						
59) How often do you	feel unsafe in	your neighborhood	ქ?			
Never	Rarely					
Sometimes	Fairly of	ten				
Frequently						

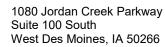








00) 1	n the past year, have you	i been allaid C	or your partitier or e	x-pa	artifer?
	Yes	No			
	Unsure	I haven't	had a partner in th	ne la	st year
61) N	Notes:				
_					
_					-
62) [During the past 12 month	s, have you ha	ad a dental probler	m tha	at you would have liked to see
а	dentist about but you did	l NOT see a d	entist?		
	Yes No				
	a. If yes, what is the n	nain reason yo	ou have not visited	the	dentist in the last 12 months?
	Fear, apprehension, pa	in			Cost
	Do not have/know a de	ntist			Did not have the time
	Cannot get to the office	/ no appointm	nent available		Other priorities
	1				
63) I	n the past 12 months, ha	ve you gone to	o a hospital emerg	jenc	y room for a dental problem?
	Yes No				
	a. If yes, check which	of the followin	ng reasons you we	nt to	the hospital emergency room:
	Dental Pain/Infection		Dental Traur	ma/A	Accident
	Other				

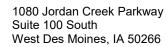








i. If you chose other, please explain:
64) On a scale of 1 – 10, how strongly do you agree with the following statement?
"I can manage and control health problems."
(10 is very strong, 1 is not strong at all)





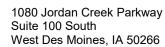




Optional – Member Survey:

We'd like to get to know you better and would like you to respond to the remaining few questions. Please indicate where you feel you belong on a scale of 1-7, where the numbers will be explained in each question.

65) Are you Family Focused (1) or Independent (7)?
Enter a number between 1 & 7:
66) Do you pay no attention to your health (1) or pay close attention to your health (7)?
Enter a number between 1 & 7:
67) I typically buy the least expensive products. (1 means 'Completely Disagree' and 7 means
'Completely Agree')
Enter a number between 1 & 7:
68) I'd rather deal with minor conditions than see a doctor. (1 means 'Completely Disagree' and
7 means 'Completely Agree')
Enter a number between 1 & 7:
69) I do research so that I can make better decisions about health treatments. (1 means
'Completely Disagree' and 7 means 'Completely Agree')
Enter a number between 1 & 7:
70) When it comes to my health, I rarely plan ahead and usually take things as they come. (1
means 'Completely Disagree' and 7 means 'Completely Agree')
Enter a number between 1 & 7:









General Information:

71) Date of Assessment:/
72) Assessment Completed By (Your Name Here)
73) Relationship to member:
(Self, Parent / Guardian, Envolve, Health Plan, Vendor, Etc.)
74) Enroll Member in Program now?
Yes No
75) Member / Guardian agrees to participate in program?
Yes No N/A