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

# Health Risk Screening – Adult (Age 18-64)

**Member Information:**

1) Preferred Mailing Address: _____
2) Preferred Phone Number: +_ (___) ___ - ____
3) Race (Check Whichever Applies):

- ☐ American Indian / Alaska Native
- ☐ Black / African American
- ☐ White
- ☐ I prefer not to answer
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ Other
- ☐ 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
- ☐ I prefer not to answer
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Other

a. If you chose other, list ethnicity here: _____

5) Language:

- ☐ English
- ☐ Other
- ☐ Spanish
- ☐ Unknown

a. If you chose other, list preferred language here: _____

6) What is your gender identity?

- ☐ Female
- ☐ Transgender
- ☐ Male
- ☐ Prefer Not to Answer
- ☐ Non-Binary

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7) What is the highest level of education you have completed?

| | |
|---|---|
| ☐ No Schooling Completed | ☐ Grade School – 8th 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) Do you have any problems with your hearing, vision, or speech requiring special services?

☐ Yes ☐ No ☐ Unknown

a. If yes, explain: _____

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**Global Health / Safety**

9) In general, how would you rate your health?

☐ Excellent ☐ Very Good ☐ Good
☐ Fair ☐ Poor ☐ Unknown

a. If you chose poor, please explain: _____

_____

10) On a scale of 0 – 10, how ready are you to make changes? _____

a. If you wrote 8, 9, or 10, tell us which changes you'd like to make: _____

_____

11) Do you have a health care provider?

☐ Yes ☐ No ☐ Unknown

*It is important to identify a doctor or health care provider to help you stay healthy and in case you get sick

a. If you answered yes, what is your health care provider's name? _____

b. Have you seen your doctor or health care provider in the last 12 months?

☐ Yes ☐ No ☐ Unknown

i. If you answered yes, what did you see your doctor for?

☐ Preventative Care ☐ Sick Care ☐ Post Hospital Visit
☐ Post Emergency Room Visit ☐ Other Visit

ii. If you chose Other Visit, what was the visit for? _____

12) How many times have you been to the hospital in the last 3 months? _____ Times

13) How many times have you been in the Emergency Department in the last 3 months? _____ Times

14) How many medicines are you currently taking that were prescribed by your health care provider? _____ Prescriptions

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a. Does anything prevent you from taking medicine?

☐ Yes ☐ No ☐ 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

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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? ____/____/____

3. Have you had a PAP smear in the last 3 years?

☐ Yes ☐ No ☐ Unknown

iii. Ages 25 – 49:

1. Are you pregnant?

☐ Yes ☐ No ☐ N/A – No sexual history ☐ Unknown

a. If you are pregnant, when is the due date? ____/____/____

2. Have you had a PAP smear in the last 3 years?

☐ Yes ☐ No ☐ Unknown

iv. Ages 50 – 64:

1. 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

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**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 ☐ No ☐ 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 ☐ No ☐ Unknown

28) In the last 12 months, did the food you bought just not last and you didn't have money to get more?

☐ Yes ☐ No ☐ Unknown

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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 ☐ No ☐ 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 ☐ No ☐ 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 ☐ No ☐ Unknown

a. If yes, what relation is your caregiver to you? (Check all that apply)

☐ Agency ☐ Family
☐ Friend ☐ Other

b. What is your caregiver's name? _____

c. What is your caregiver's phone number? (___) ___ - ____

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**Physical Health:**

34) Has a healthcare provider ever told you that you have one or more of these conditions?

(Check all that apply)

| | | |
|---|---|---|
| ☐ Arthritis | ☐ Asthma as an adult | ☐ Cancer |
| ☐ Chronic Kidney Disease | ☐ 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 **ARTHRITIS:** What type of arthritis?

☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Unknown

b. If you have had a **TRANSPLANT:** How long ago was the transplant? _____

35) On a scale of 0 – 10, how much did health problems have an effect on your daily activities (other than work at a job) during that past 7 days? (0 = Health problems had no effect, 10 = Health problems prevented me from daily activity) _____

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**Behavioral Health:**

36) In general, how satisfied are you with life?

☐ Very Satisfied ☐ Satisfied
☐ Dissatisfied ☐ Very Dissatisfied ☐ Unknown

a. If you are feeling very dissatisfied, please explain why you are feeling that way:

_____

_____

37) During the past month, have you often been bothered by feeling lonely?

☐ Yes ☐ No ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

39) During the past month, have you been bothered by little interest or pleasure in doing things?

☐ Yes ☐ No ☐ Unknown

40) Do you feel that stress is affecting your health?

☐ Yes ☐ No ☐ Unknown

a. If yes, what are your plans for managing 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

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41) During the past year, how often did you have 5 or more alcoholic drinks in one day?

☐ Never ☐ Once or Twice ☐ Monthly
☐ Weekly ☐ Daily or Almost Daily ☐ Unknown

*Avoiding heavy drinking is a great health choice

42) During the past year, how often did you use tobacco products?

☐ Never ☐ Once or Twice ☐ Monthly
☐ Weekly ☐ Daily or Almost Daily ☐ Unknown

*Quitting tobacco products is the most important thing you can do to protect your health

a. If you're currently using tobacco, would you be interested in quitting within the next month?

☐ Yes ☐ No ☐ Unknown

43) During the past year, how often did you use 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 use illegal drugs?

☐ Never ☐ Once or Twice ☐ Monthly
☐ Weekly ☐ Daily or Almost Daily ☐ Unknown

45) Do you now or have you ever had a problem with alcohol or substance misuse?

☐ Yes ☐ No ☐ Unknown

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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 behavioral health condition?

☐ Yes ☐ No ☐ Unknown

c. Are you actively receiving treatment for a behavioral health disorder?

☐ Yes ☐ No ☐ Unknown

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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 ☐ No ☐ Unknown

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**Pain / ADLS:**

50) During the last month, have you had pain that interfered with completion of your housework or your ability to work outside the home?

☐ Yes ☐ No ☐ 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 ☐ No ☐ 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

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**Supplemental Assessment:**

52) How many family members, including yourself, do you currently live with? _____

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:

a. If you chose "I do not have housing today but:", answer the following question.

i. I am:

- ☐ Staying with others
- ☐ Staying in a shelter
- ☐ Staying in a hotel
- ☐ Living outside or in a car

54) How difficult is it for you to understand information that doctors, nurses, and other health professionals tell you?

- ☐ Very Easy
- ☐ Somewhat Difficult
- ☐ Somewhat Easy
- ☐ Very Difficult

55) What is your current work situation?

- ☐ Unemployed
- ☐ Full-Time Work
- ☐ Part-Time or Temporary Work
- ☐ Otherwise unemployed but not seeking work

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56) In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply:

- ☐ Food
- ☐ Mental Health Care
- ☐ Child Care
- ☐ Transportation
- ☐ Clothing
- ☐ Utilities
- ☐ Phone
- ☐ Dental Care
- ☐ Eye-Care
- ☐ Medical Care

57) If you have trouble getting transportation when you need it, what is the MAIN reason you cannot get to where you want to go?

- ☐ I do not have trouble getting transportation
- ☐ Person who usually takes me is unavailable
- ☐ I do not have a personal vehicle
- ☐ Car broke down
- ☐ Costs too much
- ☐ 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
- ☐ A little bit
- ☐ Very much
- ☐ Somewhat
- ☐ Quite a bit

59) How often do you feel unsafe in your neighborhood?

- ☐ Never
- ☐ Sometimes
- ☐ Frequently
- ☐ Rarely
- ☐ Fairly often

60) In the past year, have you been afraid of your partner or ex-partner?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ I haven't had a partner in the last year

61) Notes: _____

_____

_____

62) During the past 12 months, have you had a dental problem that you would have liked to see a dentist about but you did NOT see a dentist?

- ☐ Yes
- ☐ No

a. If yes, what is the main reason you have not visited the dentist in the last 12 months?

- ☐ Fear, apprehension, pain
- ☐ Do not have/know a dentist
- ☐ Cannot get to the office / no appointment available
- ☐ Cost
- ☐ Did not have the time
- ☐ Other priorities

63) In the past 12 months, have you gone to a hospital emergency room for a dental problem?

- ☐ Yes
- ☐ No

a. If yes, check which of the following reasons you went to the hospital emergency room:

- ☐ Dental Pain/Infection
- ☐ Dental Trauma/Accident
- ☐ Other

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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)

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**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: _____

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**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