

## Annual Wellness Visit Health Risk Assessment

To Our Patients:

This Health Risk Assessment Questionnaire is part of your upcoming Wellness Visit. Please answer the following questions about your health and day to day activities.

This questionnaire will help your clinical team address the areas important to your overall well- being.

This questionnaire should take about 5 minutes to complete.

If you need help, please contact our office, or ask for help during your visit.

Thank you.

Please answer the following questions to the best of your ability.

1. In general, how would you rate your overall health?

<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
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2. In general, how would you rate your quality of life?

<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
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3. In general, how would you rate your mental health?

<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
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4. In the **past 7 days**, how much did your pain interfere with your day to day activities?

<input type="checkbox"/> Not at all	<input type="checkbox"/> A little bit	<input type="checkbox"/> Somewhat	<input type="checkbox"/> Quite a bit	<input type="checkbox"/> Very much
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5. Over the **last two weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Because of a health or physical problem, do you have any difficulty doing the following activities **without special equipment or help from another person**

	I do not have difficulty	Yes, I have difficulty	I am not able to do this activity unassisted
Bathing			
Dressing and grooming			
Eating			
Using the toilet			
Getting in and out of bed or chairs			
Managing medications			
Managing money			
Household activities, like food prep, laundry, and housekeeping			
Can you shop for groceries and clothes?			
Can you get to places out of walking distance?			

7. In the past 6 months, have you accidentally leaked urine?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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8. A fall is when your body goes to the ground without being pushed. Did you fall in the **past 12 months?**

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, how many times? \_\_\_\_\_ Were you injured? \_\_\_\_\_

Do you feel unsteady when standing or walking?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Do you worry about falling?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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9. What is your walking status?

<input type="checkbox"/> Walk unassisted	<input type="checkbox"/> Use a cane or walker	<input type="checkbox"/> Use a wheelchair
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10. Do you think you have a hearing problem, or do others think you have a hearing problem?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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11. Do you wear hearing aids?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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12. Do you have difficulty driving, watching TV, reading, or doing any of your daily activities?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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13. How is your appetite?

<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
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14. How many servings of fruits and vegetables do you eat on a typical day?

<input type="checkbox"/> More than 5	<input type="checkbox"/> 3-5 servings	<input type="checkbox"/> 1-2 servings	<input type="checkbox"/> I do not eat fruit and vegetables
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15. Does the place where you live have the following safety concerns addressed?

	Yes	No
Loose rugs secured	<input type="checkbox"/>	<input type="checkbox"/>
Carbon Monoxide detector	<input type="checkbox"/>	<input type="checkbox"/>
Working smoke alarm	<input type="checkbox"/>	<input type="checkbox"/>
Good lighting in walkways	<input type="checkbox"/>	<input type="checkbox"/>
Solid hand rails on stairs	<input type="checkbox"/>	<input type="checkbox"/>
Non-slip flooring in tub or shower, or grab bars	<input type="checkbox"/>	<input type="checkbox"/>

15. What is your usual form of transportation?

<input type="checkbox"/> Drive self	<input type="checkbox"/> Driven by others	<input type="checkbox"/> Bus/taxi/paratransit
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16. Is your Advance Healthcare Directive on file with us?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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17. In the past four weeks, would there have been someone available (family, friend, etc.) to help you if you would have needed and wanted the help? For example. If you felt lonely, depressed, got sick and needed to stay in bed, needed help with daily chores, or just needed to take care of yourself.

Yes, as much as <input type="checkbox"/> needed	Yes, quite a <input type="checkbox"/> bit	<input type="checkbox"/> Yes, some	<input type="checkbox"/> Yes, a little	No, not at <input type="checkbox"/> all
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18. How many days per week do you usually exercise? \_\_\_\_\_

19. If you exercise, on average, how long is your exercise session? \_\_\_\_\_

20. How intense is your physical exercise?

Very heavy running, stair <input type="checkbox"/> climbing	Heavy jogging, <input type="checkbox"/> swimming	Moderate brisk <input type="checkbox"/> walking	Light stretching or <input type="checkbox"/> slow walking
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21. In a typical week, how many days do you drink alcohol (beer, wine, liquor, cocktails)?  
\_\_\_\_\_ day(s) a week

22. On days when you do drink how many alcoholic drinks do you consume? \_\_\_\_\_  
(one drink= 12 oz of beer, 5 oz. of wine, or 1.5 oz. of distilled spirits)

23. What is the most number of drinks you've had in one day in the past 6 months? \_\_\_\_\_

24. To ensure optimal care coordination, please list below all providers you see on a regular basis.

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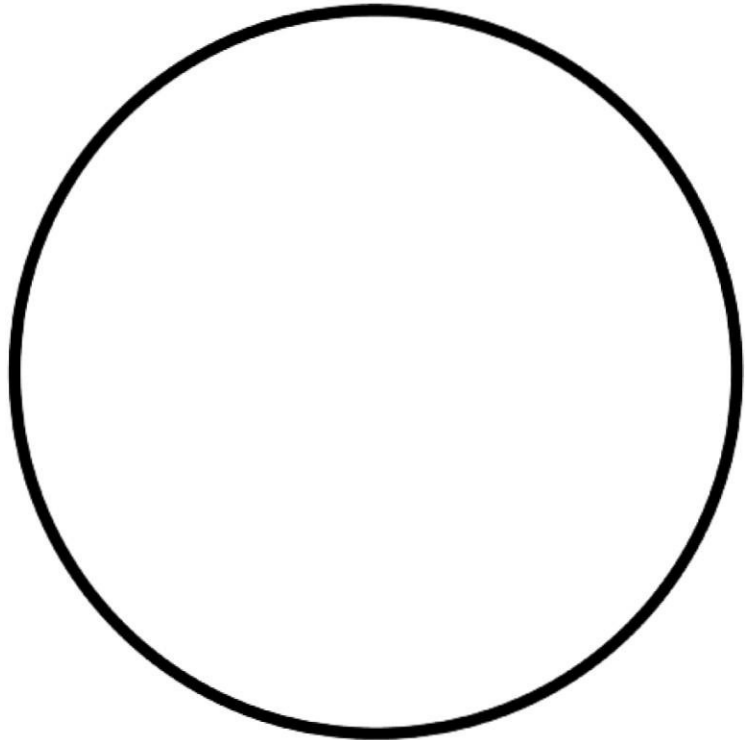
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**Please wait for your  
provider to complete  
this portion**



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