The Clinic of Welsh

HEALTH RISK ASSESSMENT

NAME:_____ DATE:___/___/_____Acct#_____

SELF ASSESSMENT

1. What statement best describes your health status at this time?

___I feel well ___My health is getting better
___My health is getting worse ___I do not feel well today
_____.

2. How confident are you that you can control and manage most of your health problems?

___Confident ___Somewhat confident
___Not very confident ___I do not have any health problems

3. What level of health care best describes what you are receiving at this time

___Too much ___The right amount ___Not enough

4. Please select all of the following that apply to your health at this time.

___Increased stress ___Increased anxiety/nervousness
___Social isolation ___Physical inactivity
___Current smoker ___Second hand smoke
___Poor nutrition ___Illicit drug use
___Inability to take medications (I can't afford)
___None

5. Please select the items you are able to do on your own.

___Dressing ___Bathing ___Walking
___Using the toilet ___Shopping ___Housekeeping
___Transportation ___Handling your money

6. How safe do you feel?

___I feel safe all of the time
___I feel safe most of the time
___I don't feel safe most of the time

7. Patient feels unsafe due to the following:

___ Poor Hearing
___ Poor Vision

8. Do you always fasten your seat belt when you are in a car?

___yes ___no

9. In the past 7 days, how many days did you exercise?

____ days

10. And for how long?

_____ Minutes per day

11. How intense was your typical exercise?

_____ I am currently not exercising _____ Heavy (like jogging or swimming
_____ Light (like stretching or slow walking) _____ Very Heavy (like fast running or stair climbing)
_____ Moderate (like brisk walking)

12. In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat Eat each day? (1 serving = 1 slice of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready to eat cereal, ½ cup of cooked oatmeal, or ½ cup of cooked brown rice or whole wheat pasta) _____ Servings per day

13. In the past 7 days, how many servings of fruit or vegetables did you typically eat each day? (1 serving = 1 cup of fresh vegetables, ½ cup cooked vegetables or 1 medium piece of fruit) ____ Servings per day

14. In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (fried chicken/fish/fries, bacon, potato chips, corn chips, doughnuts, creamy salad dressings, whole milk, cream, cheese, or mayonnaise) ____servings per day

15. In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day? ____beverages per day

16. In the past 7 days, how often have you felt sleepy in the daytime?
___always ___usually ___sometimes ___rarely ___never

17. How many hours of sleep do you usually get each night?
___less than 4 ___4-5 ___6-8 ___8+.

18. Do you snore, or has anyone told you that you snore?
___no ___yes ___yes, but controlled with CPAP

19. How would you describe the condition of your mouth and teeth, including false teeth?
___excellent ___very good ___fair ___poor

20. In the last 30 days, have you used tobacco?
___ no ___＜1ppd ___1ppd ___2 or >ppd ___yes, vape use

21. If you currently use tobacco, are you interested in quitting tobacco use?
___yes ___no ___I do not use tobacco

22. Have you had a Bone Mass Measurement test done?
For patients who are at risk for losing bone mass; ≤65 y/o with history of fracture
___n/a ___yes Date:___/___/_____ ___no

23. In the past 10 years have you had a screening colonoscopy?
This time frame is appropriate for patients who are ≥50 years old and do not have a family history of colon cancer, a personal history of polyps or other risk factors.
___n/a __yes Date:___/___/_____ ___no

24. In the past 12 months have you had a fecal occult blood test?
___n/a ___yes Date:___/___/_____ ___no

25. Females: In the past 12 months, have you had a screening mammography?

26. Females: In the past 2 years, have you had a screening breast and pelvic examination?

27. Males: In the past 12 months, have you had a digital rectal exam or a prostate specific antigen (PSA)?

28. Have you received the flu vaccine? ___yes Date:___/___/_____ ___no ___I don't know

Patient Health Questionnaire, edited PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use an X to indicate answer)	**Not at all 0**	**Several Days 1**	**More than half of the days 2**	**Nearly everyday 3**
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself- or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				
Welsh staff only **Subtotal:**				

1-4 Minimal 5-9 Mild 10-14 Moderate 15-19 Moderate Severe 20-27 Severe **Total: /27**

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Score: /27

1-4 Minimal 5-9 Mild 10-14 Moderate 15-19 Moderate Severe 20-27 Severe

DRUG ABUSE DAST-10

1.Have you used drugs other than those required for medical reasons?

○ No ○ Yes

2.Do you abuse more than one drug at a time?

○ No ○ Yes

3.Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes.")

○ No ○ Yes

4.Have you ever had blackouts or flashbacks as a result of drug use?

○ No ○ Yes

5.Do you ever feel bad or guilty about your drug use?

○ No ○ Yes

6.Does your spouse (or parents) ever complain about your involvement with drugs?

○ No ○ Yes

7.Have you neglected your family because of your use of drugs?

○ No ○ Yes

8.Have you engaged in illegal activities in order to obtain drugs?

○ No ○ Yes

9.Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?

○ No ○ Yes

10.Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?

○ No ○ Yes

NAME_____

DATE_____ SCORE : /10

ALCOHOL AUDIT - C

How often do you have a drink containing alcohol?

Never+0 Monthly or less+1
2-4 times a month+2 2-3 times a week+3
4 or more times a week+4

How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2+0 3 or 4+1
5 or 6+2 7 to 9+3
10 or more+4

How often do you have six or more drinks on one occasion?

Never+0 Less than monthly+1
Monthly+2 Weekly+3
Daily or almost daily+4

SCORE_____

C: Have you ever felt you should Cut down on your drinking?

Yes+1 No+0

A: Have people Annoyed you to by criticizing your drinking?

Yes+1 No+0

G: Have you ever felt Guilty about your drinking?

Yes+1 NO+0

E: Have you ever had a drink first thing in the morning (Eye opener)?

Yes+1 No+0

SCORE_____

NAME_____
DATE_____