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. (Fall Assessment)

7. 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
   - ___If you don't feel safe, is it because:
     - ___I don't hear well ___I don't see well
     - ___domestic issue:_____

8. Patient feels unsafe due to the following:
   - ___ Poor Hearing
   - ___ Poor Vision

9. Do you always fasten your seat belt when you are in a car?
   - ___yes ___no

10. Do you ever drive after drinking, or ride with a driver who has been drinking?
    - ___yes ___no ___I do not drink alcohol

Falls Efficacy Scale-International, edited

Please reply thinking about how you usually do the activity. If you currently don't do the activity, please answer to show how you think you would be concerned about falling IF you did the activity.

	Not at all concerned 1	Somewhat concerned 2	Fairly concerned 3	Very concerned 4
Cleaning the house (e.g. sweep vacuum, dust)				
Getting dressed or undressed				
Preparing simple meals				
Taking a bath or shower				
Going shopping				
Getting in or out of a chair				
Going up or down stairs				
Walking around the neighborhood				
Reaching for something above your head or on the ground				
Going to answer the phone before it stops ringing				
Walking on a slippery surface (e.g. wet or icy)				
Visiting a friend or relative				
Walking in a place with crowds				
Walking on an uneven surface (e.g. rocky ground, poorly maintained pavement)				
Walking up or down a slope				
Going out to a social event (e.g. religious service, family gathering)				
Welsh staff only Subtotal:				

1-16 Not 17-32 Somewhat 33-48 Fairly 49-64 Very Concerned **Total /64**

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

11.

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

12. In the past 7 days, how many days did you exercise?
_____ Days

13. And for how long?
_____ Minutes per day

14. How intense was your typical exercise?
___Light (like stretching or slow walking)
___Moderate (like brisk walking)
___Heavy (like jogging or swimming)
___Very Heavy (like fast running or stair climbing
___I am currently not exercising

15. In the past 7 days, how many servings of high fiber or whole grain foods did you typically 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

16. In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1 cup of fresh vegetables, ½ cup of cooked vegetables or 1 medium piece of fruit. 1 cup=size of baseball) _____servings per day

17. 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

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

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

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

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

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

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

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

25. How often to you have a drink containing alcohol?
___ Never _____ Monthly or Less
___2 to 4 times a month _____ 4 or more times a week

26. How <u>many drinks</u> containing alcohol do you have on a typical day when you are drinking?
___ 1 or 2 ___ 3 or 4 ___5 or 6 ___ 7,8,or 9 ___ 10 or more

27. How often do you have six or more drinks on one occasion?
___ Never ___ Less than monthly ___Weekly ___Daily or almost daily

28. Do you ever drive after drinking, or ride with a driver who has been drinking?
___ Yes ___ No

29. How often during the last year have you failed to do what was normally expected from you because of drinking?
___ Never ___ Less than monthly ___Weekly ___Daily or almost daily

30. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
___ Never ___Less than monthly ___Weekly ___Daily or almost daily

31. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?
___ Never ___Less than monthly ___Weekly ___Daily or almost daily

32. How often during the last year have you had a feeling of guilt or remorse after drinking?
___Never ___Less than monthly ___Weekly ___Daily of almost daily

33. Have you or someone else been injured as a result of your drinking?
___Never ___Less than monthly ___Weekly ___Daily or almost daily

34. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?
___ No ___Yes, but not in the last year ___Yes, during the last year

35. 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

36. 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

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

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

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

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

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

42. If you are ≥65, have you received the pneumonia vaccine?
___yes Date:___/___/_____ ___no ___I don't know