Health Risk Assessment

BAPTIST Primary Care

Changing Health Care for Good.®

Name:_____ Date: _____

Date of Birth:_____

Please complete this checklist before seeing your medical provider. Your responses will help you receive the best possible care.

Self-Assessment of Overall Health

1. During the past four weeks, how would you rate your health in general?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. During the past four weeks, how much have you been bothered by emotional problems (anxiety, depression, irritability, sadness) that have limited your social actives with family, friends or neighbors?
   ☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

3. During the past four weeks, how much bodily pains have you generally had?
   ☐ No Pain ☐ Very mild pain ☐ Mild Pain ☐ Moderate pain ☐ Severe Pain

4. During the past four weeks, what was the hardest physical activity you could do for at least 2 minutes?
   ☐ Very heavy ☐ Heavy ☐ Moderate ☐ Light ☐ Very Light

5. During the past four weeks, was someone available to you if you needed and wanted help?
   (For example: if you felt very nervous, lonely or blue; go sick and had to stay in bed; or needed help just taking care of yourself.)
   ☐ Yes, as much as I wanted ☐ Yes, quite a bit ☐ Yes, a little ☐ Not at all

6. Have you had unintended weight loss or gain? ☐ Yes ☐ No

Actives of Daily Living (ADL)

7. Have you fallen two or more times in the past year? ☐ Yes ☐ No

8. Are you afraid of falling? ☐ Yes ☐ No

9. Do you need the help of another person to perform your personal care needs such as eating, bathing, dressing, toileting, or getting around the house? ☐ Yes ☐ No

10. How often during the past four weeks have you been bothered by any of the following problems?

Trouble eating 2 meals a day	☐ Never	☐ Seldom	☐ Sometimes	☐ Often	☐ Always
Teeth or denture problems	☐ Never	☐ Seldom	☐ Sometimes	☐ Often	☐ Always
Swallowing or choking problems	☐ Never	☐ Seldom	☐ Sometimes	☐ Often	☐ Always
Difficulty shopping or cooking	☐ Never	☐ Seldom	☐ Sometimes	☐ Often	☐ Always

Instrumental Activities of Daily Living (IADL)

11. Can you drive or travel by bus or taxi independently? ☐ Yes ☐ No

12. Do you have easy access to transportation? ☐ Yes ☐ No

13. Can you do housework without help? ☐ Yes ☐ No

14. Can you do your finances without help? ☐ Yes ☐ No

15. How often do you have trouble taking medicines the way you have been told to take them?
    ☐ I do not have to take medicine ☐ I always take them as prescribed
    ☐ Sometimes I take them as prescribed ☐ I seldom take them as prescribed

16. Do you fasten your seat belt when you are in a car?
    ☐ Yes, Always ☐ Yes, Usually ☐ Yes, Sometimes ☐ No

Behavioral Risks

17. Are you a smoker? ☐ Yes ☐ No

18. During the past four weeks, how many drinks of wine, beer or other alcoholic beverages did you have?
    ☐ 10 or more drinks ☐ 6-9 drinks per week ☐ 2-5 drinks per week
    ☐ One drink or less per week ☐ No alcohol at all

19. Do you exercise for about 20 minutes 3 or more times per week?
    ☐ Yes, most of the time ☐ Yes, some of the time ☐ No , I usually do not exercise this much

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