Complete Family Care
Health Risk Assessment

Patient Name: _____ Date of Birth:_____

Primary Care Provider's Name: _____

Does someone at home help you with your health care?

Caregiver Name: _____ Phone number: _____

How do you know this person? (For example, is this your sister, your father, or your friend, a hired caregiver/nurse, or do you live in assisted or independent living community?

_____

Name of specialists or other healthcare providers:

Name	They help take care of my:	Last Visit Date:	Phone number (if known)

Health problems or diagnoses experienced by your family members that are new <u>within the past year:</u>

Your Mother:	Your Father:	Your Siblings:	Your Children:

Changes in Your Health History

Have you had any new surgeries, procedures or new medical diagnosis in the last year? If so, please list below. (Please list known dates of last colonoscopy, cologuard, mammogram, or bone density scan)

1.	4.
2.	5.
3.	6.

HOW HEALTHY DO YOU FEEL TODAY? (Circle all that apply):

I feel well today. I feel my health is getting better.

I feel my health is getting worse. I feel unwell today.

I am having these problems: _____

SMOKING ASSESSMENT (Please check which best describes your smoking status):

____ Non-smoker (never smoked)

____ Past smoker Year Quit_____ Packs/day smoked (average)_____

____ Current smoker Packs/day currently smoke (average)____ Number of years Smoked _____

Have you tried quitting in the past? _____

Are you wanting to quit smoking now? _____

SUBSTANCE USE DISORDERS

Do you use any illegal drugs or take any prescription medications that have not been prescribed to you?

_____ **YES** (Please Describe): _____

_____ **NO**

ALCOHOL ASSESSMENT

Do you consume alcoholic beverages? **YES** **NO**

How many nights a week do you consume alcoholic beverages? _____

When you consume alcoholic beverages, how many drinks do you consume in one evening? _____

What type of alcoholic beverages do you consume? _____

VISION ASSESSMENT

Have you had an eye exam in the last year? **YES** **NO**

Date of last exam_____

Eye doctor's name? _____

HEARING ASSESSMENT

Do you wear hearing aids? **YES** **NO**

Are you currently under the care of an audiologist or Ear Nose and Throat specialist (ENT) that has tested your hearing? **YES** **NO**

Name of Specialist_____

FALL RISK ASSEMENT (please circle one):

Have you fallen in the last 6 months?	**YES**	**NO**
Do you live alone?	**YES**	**NO**
Do you use a walking aide?	**YES**	**NO**
Do you feel steady on your feet?	**YES**	**NO**

DO ANY OF THE FOLLOWING HEALTH RISKS APPLY TO YOU? (Circle all that apply):

Feelings of anxiety or depression
Physical inactivity/limited mobility
Trouble with my memory
Second Hand Smoke
Inability to take medications (cannot afford or do not remember)
Problems maintaining or increasing your physical activity or exercise program
Increased stress
Social Isolation
Trouble with vision or hearing
Poor nutrition/lack of balanced diet
Inadequate nutrition/access to food

Other:_____

Urinary Incontinence Risk Assessment

Questionnaire for Urinary Incontinence Diagnosis

Do you leak urine (even small drops), wet yourself, or wet your pads or undergarments ...	**None of the time**	**Rarely**	**Once in a while**	**Often**	**Most of the time**	**All of the time**
1. When you **cough** or **sneeze**?	☐	☐	☐	☐	☐	☐
2. When you **bend down** or **lift something up**?	☐	☐	☐	☐	☐	☐
3. When you **walk quickly, jog,** or **exercise**?	☐	☐	☐	☐	☐	☐
4. While you are **undressing** in order to use the **toilet**?	☐	☐	☐	☐	☐	☐
5. Do you get such a **strong and uncomfortable need** to urinate that you leak urine (even small drops) or wet yourself before reaching the toilet?	☐	☐	☐	☐	☐	☐
6. Do you have to **rush to the bathroom** because you get a **sudden, strong need** to urinate?	☐	☐	☐	☐	☐	☐

Scoring:

Each item scores 0 (None of the time), 1 (Rarely), 2 (Once in awhile), 3 (Often), 4 (Most of the time) or 5 (All of the time).

Responses to items 1, 2 and 3 are summed for the Stress score; and responses to items 4, 5, and 6 are summed for the Urge score.

QUID Stress Scale Score: ___ QUID Urge Scale Score: ___ Quid Total Score: ___

ACTIVITIES OF DAILY LIVING ASSESSMENT

Name:_____ DOB:_____ Date of Service_____

On a Normal day do you need help with any of the following things?

Check YES or NO	YES	NO		YES	NO
Feeding myself			Using the telephone		
Brushing my hair or teeth			Managing my medications		
Using the toilet			Doing basic housework		
Showering or bathing			Handling transportation		
Getting dressed			Managing my finances		
Walking or moving from one place to another			Shopping or preparing my meals		

DEPRESSION SCREENING

Over the past two weeks, have you felt anxious, down or depressed? (Circle one):
Yes No
Over the past two weeks, have you experienced little interest or pleasure in doing things? (Circle one):
Yes No

Mood Assessment

	Over the last 2 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
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired of having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself – or that you're a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentration on things, such as reading the newspaper or watching television	0	1	2	3
8	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	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
	Totals				

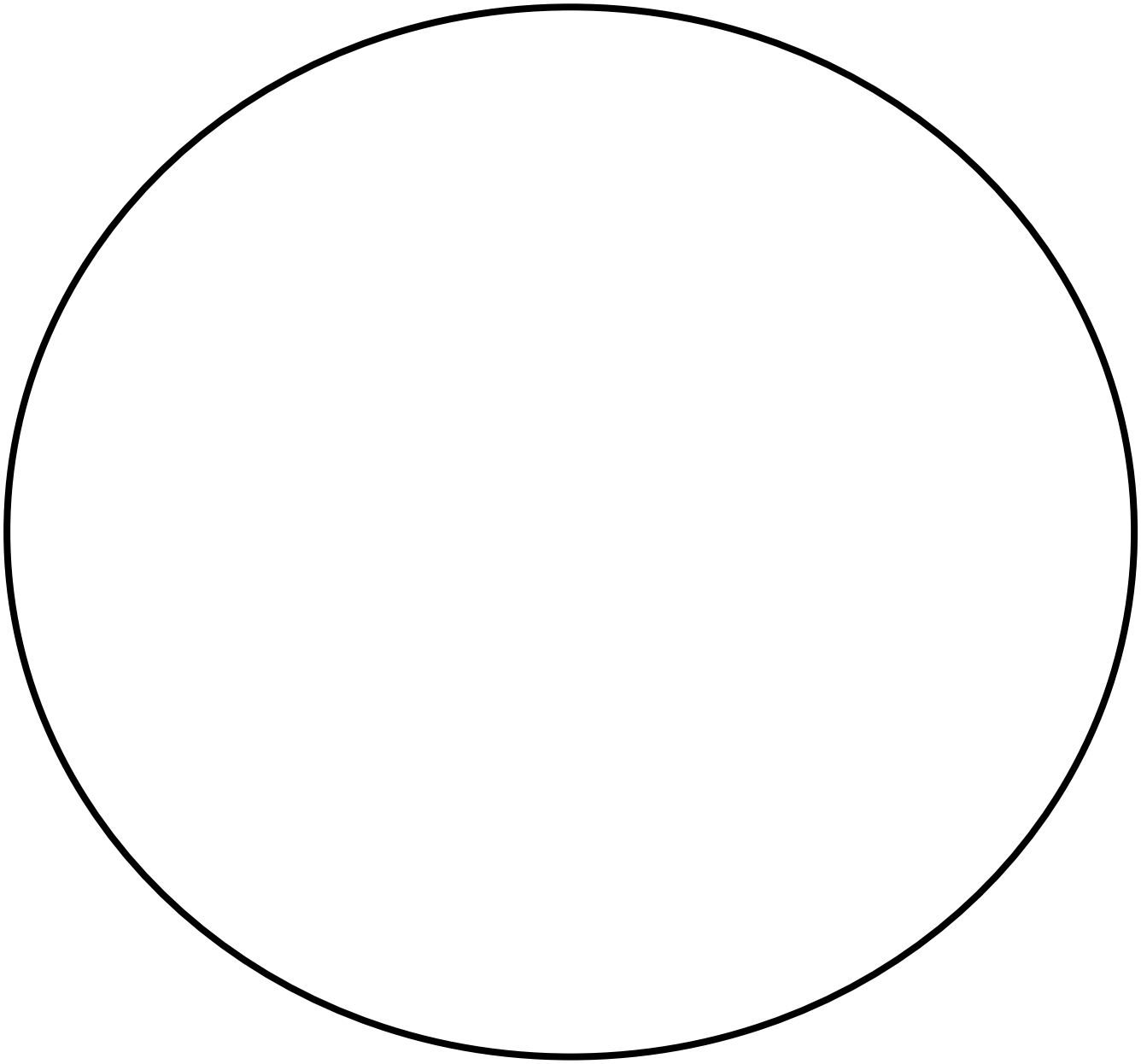
If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult

Name:_____ DOB:_____ Date of Service_____

Mini-Cog Assessment

(Please wait to fill this out until your appointment. You will be given instructions at that time.)



Word recall version: _____

_____ _____ _____

Name:_____ DOB:_____ Date of Service_____