CHA Health Plan

Health Risk Assessment Form

MEMBER NAME: _____ MEMBER ID #: _____ TODAY'S DATE: _____

PRIMARY CARE PHYSICIAN: _____

HAVE YOU EVER HAD OR BEEN TREATED FOR ANY OF THE THESE:

Alzheimer's Disease/Dementia	□ YES □ NO	High Blood Pressure	□ YES □ NO
Amputation	□ YES □ NO	High Cholesterol/Triglycerides	□ YES □ NO
Asthma	□ YES □ NO	HIV or AIDS	□ YES □ NO
Arthritis or pain joints	□ YES □ NO	Kidney Disease and/or Dialysis	□ YES □ NO
Birth Defects or Conditions (cerebral palsy, congenital disease, etc.)	□ YES □ NO	Liver Disease, Cirrhosis or Hepatitis	□ YES □ NO
Cancer	□ YES □ NO	Lung Disease (Emphysema, COPD)	□ YES □ NO
Diabetes	□ YES □ NO	LUPUS	□ YES □ NO
Depression/Mental Illness	□ YES □ NO	Multiple Sclerosis or any paralysis	□ YES □ NO
Epilepsy/Seizures	□ YES □ NO	Organ Transplant (liver, kidney, etc.)	□ YES □ NO
Heart Problems	□ YES □ NO	Sickle Cell Disease or Anemia	□ YES □ NO
Hemophilia	□ YES □ NO	Stroke	□ YES □ NO

PLEASE ANSWER THESE QUESTIONS:

Are your childhood immunizations (shots) up to date?	□ YES □ NO
Do you need help getting transportation for your doctor visits or tests?	□ YES □ NO
In the past year have you felt sad or down for more than 2 months?	□ YES □ NO
Do you ever feel in trouble or that you are being physically, mentally or sexually abused?	□ YES □ NO
In the previous 3 months, have you had difficulty meeting your living expenses?	□ YES □ NO
Have you seen a dentist in the past 12 months?	□ YES □ NO
Do you have any tooth pain or bleeding from your gums?	□ YES □ NO
Have you lost or gained more than 10 pounds in the last 6 months without trying?	□ YES □ NO
Are you pregnant?	□ YES □ NO
If "Yes", what is the date you are expected to deliver?	
Are you currently receiving WIC?	□ YES □ NO
Are you receiving Services from the Healthy Start Program?	□ YES □ NO
Have you started the process for your newborn baby to be enrolled with Medicaid?	□ YES □ NO
Have you had a baby within the past 2 months?	□ YES □ NO
Would you like information on Family Planning?	□ YES □ NO
Would you like information on Teen Pregnancy Prevention?	□ YES □ NO
Do you need help with any of the following: bathing, dressing, eating, walking, etc.?	□ YES □ NO
Do you socialize with others regularly?	□ YES □ NO
Do you foresee your health as getting a lot worse in the next 6 months?	□ YES □ NO
Do you find that you have become more forgetful than you used to be?	□ YES □ NO
Have you been to an Emergency Room or Hospitalized within the last 90 days?	□ YES □ NO
Do you now have any medical equipment (like a wheelchair, aerosol machine, oxygen, etc.) that was given to you by a previous insurance company or Medicare/Medicaid?	□ YES □ NO
If "YES", which one do you now have?	

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Do you smoke?		□ YES □ NO
	If "YES", would you like to get information to help you to stop smoking?	□ YES □ NO
Do you think you have a problem with drinking alcohol or drugs?		□ YES □ NO
	If "YES", would you like to get help with this problem?	□ YES □ NO
When was your last flu shot? □ Never □ Within the past 18 months □ More than 18 months		
When was your last eye exam (with dilated pupils)? □ Never □ Less than 12 months ago □ More than 12 months ago		
How many different medications do you take every day? □ None □ 1 to 3 □ 4 to 6 □ More than 6		
If you now have pain, please tell us how bad the pain is, with 1 being very little pain, 5 being medium pain, and 10 being very bad pain: □ I have no pain □ 1 to 3 □ 4 to 6 □ 7 to 10		
Who do you live with: □ Alone □ Spouse/Significant Other □ Family/Friends □ Shelter □ Assisted Living Facility/Nursing Home □ Homeless □ Other _____		

Please sign and date on the line below. Return this form to us in the stamped envelope or call Member Services toll free at ***1-877-577-9043 (TTY 711)*** if you need help completing this form.

DATE OF BIRTH: _____ ☐ MALE ☐ FEMALE

CURRENT ADDRESS:

_____

STREET CITY STATE ZIP CODE

HOME PHONE #:_____ CELL PHONE OR OTHER PHONE NUMBER:_____

EMERGENCY CONTACT NAME: _____ PHONE #: _____

YOUR PRIMARY LANGUAGE IS: ☐ ENGLISH ☐ SPANISH ☐ OTHER (Specify) _____

_____/_____ _____

PRINT NAME/SIGNATURE OF PERSON COMPLETING THIS FORM RELATIONSHIP TO THE MEMBER? (e.g., Self, Spouse, etc.)