Health Risk Assessment

Today's date: _____ / _____ / _____

Your Name: _____ Date of Birth: _____ / _____ / _____

Age _____Under 65 _____ 65-69 _____ 70-79 _____ 80 or older
Gender _____ Male _____ Female

1) During the past four weeks, how much bodily pain have you generally had?
____No pain ____Very mild pain ____Mild pain ____Moderate pain ____Severe pain

2) During the past four weeks, was someone available to help you if you needed and wanted help?
(For example: if you felt very nervous or lonely; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help taking care of yourself)
____Yes, as much as I wanted ____ Yes, quite a bit ____Yes, some ____Yes, a little ____No, not at all

3) During the past four weeks, what was the hardest physical activity you could do for at least two minutes?
____Very heavy ____Heavy ____Moderate ____Light ____Very light

4) Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?) ____Yes ____No

5) Can you go shopping for groceries or clothes without someone's help? ____Yes ____No

6) Can you prepare your own meals? ____Yes ____No

7) Can you do your housework without help? ____Yes ____No

8) Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house? ____Yes ____No

9) Can you handle your own money without help? ____Yes ____No

10) During the past four weeks, how would you rate your health in general?
____Excellent ____Very good ____Good ____Fair ____Poor

11) How have things been going for you during the past four weeks?
____Very well, could hardly be better ____Pretty well ____Good and bad parts about equal
____Pretty bad ____Very bad, could hardly be worse

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12) Are you having difficulties driving your car?
____Yes, often ____Yes, sometimes ____No ____Not applicable, I do not use a car

13) Do you always fasten your seat belt when you are in a car? ____Yes, always ____Yes, sometimes ____No

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

Falling/dizzy when standing up	____Never	____Seldom	____Sometimes	____Often	____Always
Sexual problems	____Never	____Seldom	____Sometimes	____Often	____Always
Teeth or denture problems	____Never	____Seldom	____Sometimes	____Often	____Always
Problems using the telephone	____Never	____Seldom	____Sometimes	____Often	____Always

15) Are you a smoker? ____Yes, and I might quit ____Yes, but I'm not ready to quit ____No

16) During the past four weeks, how many drinks of wine, beer, or other alcoholic beverages did you have?
____10 or more drinks per week ____6-9 drinks per week ____2-5 drinks per week
____One drink or less per week ____No alcohol at all

17) Do you exercise for about 20 minutes three or more days a week?
____Yes, most of the time ____Yes, some of the time ____No, I usually do not exercise this much

18) Have you been given any information to help you with the following:
Hazards in your house that might hurt you? ____Yes ____No
Keeping track of your medication? ____Yes ____No

19) 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

20) How confident are you that you can control and manage most of your health problems?
____Very confident ____Somewhat confident ____Not very confident
____I do not have any health problems

21) Do you have a Living Will? ____Yes ____No ____Not Sure