HEALTH RISK ASSESSMENT

UMPQUA HEALTH

Umpqua Health Alliance is here to help you with your health. We ask you these questions to understand your needs. You can skip questions that do not apply to you. Please complete all questions related to your care coordination needs. What you choose to share with us will be shared with your care team, to reduce the need to ask the same questions. Information collected in this screening is protected by privacy practices.

Alternative languages and formats:

This form is available in other languages, large print, braille or formats that suit your needs. You can also request a language interpreter. Please call 888-788-9821 (TTY/TDD 711).

Puede obtener esta forma en otros idiomas, en letra grande, en braille o en el formato que prefiera. También puede solicitar un intérprete. Llame al 541-229-4842 o al TTY 711.

Personal Information:

First Name: _____ Last Name: _____

Member ID#: _____ Pronouns: _____ Date of Birth *(MM/DD/YYYY)*: _____

Email: _____ Phone: _____

Would you like us to email or text you? ☐ Yes ☐ No

Physical Street Address: _____

City: _____ State: _____ Zip: _____

Mailing Street Address: _____

City: _____ State: _____ Zip: _____

Phone: 541-229-4842
Toll free: 866-672-1551
TTY: 541-440-6304 | 711

Email: *UHCustomerCare@umpquahealth.com*

Website: *www.umpquahealth.com*

Address: 3031 NE Stephens Street, Roseburg, OR 97470

Personal Characteristics:

What language would you prefer to use when communicating with someone outside the home about important matters such as medical, legal, or health information?

- ☐ English
- ☐ Spanish
- ☐ Other: _____

What language would you prefer to use to read important written information such as medical, legal, or health information?

- ☐ English
- ☐ Spanish
- ☐ Other: _____

Do you have any cultural, religious, or spiritual beliefs that could affect your care?

- ☐ Yes
- ☐ No

What is your gender? *(Check all that apply)*

- ☐ Boy or Man
- ☐ Girl or Woman
- ☐ Agender/ No gender
- ☐ Non-binary
- ☐ Other: _____
- ☐ Transgender
- ☐ Questioning/ Exploring
- ☐ Decline to answer

What is your sex?

- ☐ Female
- ☐ Male
- ☐ Other: _____
- ☐ Intersex
- ☐ Decline to answer

What is your sexual orientation?

- ☐ Asexual
- ☐ Bisexual
- ☐ Gay
- ☐ Heterosexual/ Straight
- ☐ Same Gender Loving
- ☐ Other: _____
- ☐ Lesbian
- ☐ Pansexual
- ☐ Queer
- ☐ Questioning/ Exploring
- ☐ Decline to answer

Social Needs:

If you decline to be screened for social needs, you may skip to physical and dental health needs.

Would you like to be screened for social needs?

- ☐ Yes
- ☐ No, I decline

What language are you most comfortable speaking?

- ☐ English
- ☐ Spanish
- ☐ Other: _____
- ☐ Decline to answer

Are you Hispanic or Latino?

- ☐ Yes
- ☐ No
- ☐ Decline to answer

Which race(s) are you? *(Check all that apply)*

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Other: _____
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Decline to answer

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Have you been discharged from the United States Armed Forces?

☐ Yes ☐ No ☐ Decline to answer

Are you a refugee?

☐ Yes ☐ No ☐ Decline to answer

In the past year, have you or your family members been unable to get any of the following when needed?

☐ Child Care
☐ Clothing
☐ Food
☐ Health Care *(Medical, Dental, Mental, Vision)*
☐ Medicine
☐ Phone
☐ Utilities
☐ Decline to answer
☐ Other: _____

What is your current housing situation?

☐ I have housing
☐ I do not have housing *(Staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)*
☐ Decline to answer

Are you worried about losing your housing?

☐ Yes ☐ No ☐ Decline to answer

How many family members, including yourself, do you currently live with?

Number: _____ ☐ Decline to answer

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?
(Check all that apply)

☐ Yes, it has kept me from medical appointments or from getting my medications.
☐ Yes, it has kept me from non-medical meetings, appointments, work, or from things that I need.
☐ Decline to answer
☐ No

What is the highest level of school that you have finished?

☐ Less than high school degree
☐ High school diploma/GED
☐ More than high school
☐ Decline to answer

What is your current work situation?

☐ Full-Time Work
☐ Part-Time or Temporary Work
☐ High school Diploma/GED
☐ Unemployed
☐ Decline to answer

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At any point in the past two years, has seasonal or migrant farm work been your or your family's main source of income?

☐ Yes ☐ No ☐ Decline to answer

During the past year, what was the total combined income for you and the family members you live with? *This information will help us determine if you are eligible for any benefits.*

$ _____ ☐ Decline to answer

What is your main insurance?

☐ None/uninsured
☐ CHIP Medicaid
☐ Medicaid *(UHA/OHP)*
☐ Medicare Advantage
☐ Medicare
☐ Other Public Insurance *(CHIP)*
☐ Other Public Insurance *(Not CHIP)*
☐ Private Insurance
☐ Veterans Affairs *(VA)*

In the past year, have you spent more than two nights in a row in a jail, prison, detention center, or juvenile correction facility?

☐ Yes ☐ No ☐ Decline to answer

Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

☐ Not at all
☐ Somewhat
☐ Very much
☐ A little bit
☐ Quite a bit
☐ Decline to answer

How often do you see or talk to people that you care about and feel close to? *(Talking on the phone, visiting friends or family, going to church or club meetings)*

☐ Less than once a week
☐ 1 or 2 times a week
☐ 3 to 5 times a week
☐ 5 or more times a week
☐ Decline to answer

Do you feel physically and emotionally safe where you currently live?

☐ Yes ☐ Usure
☐ No ☐ Decline to answer

In the past year, have you been afraid of your partner or ex-partner?

☐ Yes ☐ Usure
☐ No ☐ Decline to answer
☐ I have not had a partner in the past year

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Physical and Dental Health Needs:

Would you like to be screened for physical and dental health needs?

- ☐ Yes
- ☐ No, I decline

Would you like help with your physical health?

- ☐ Yes
- ☐ No

Would you like help with your dental health?

- ☐ Yes
- ☐ No

How often do you see your primary care provider?

- ☐ I need help getting primary care
- ☐ Every 6 months
- ☐ Once a year
- ☐ I don't know
- ☐ Decline to answer
- ☐ Other: _____

How often do you see your dental provider?

- ☐ I need help getting primary care
- ☐ Every 6 months
- ☐ Once a year
- ☐ I don't know
- ☐ Decline to answer
- ☐ Other: _____

Do you have any of the following dental concerns? *(Check all that apply)*

- ☐ Pain or aching from chewing or sensitivity to hot and cold
- ☐ Ongoing dental pain
- ☐ Fear of dental care
- ☐ Broken Tooth
- ☐ Cavities
- ☐ Decline to answer

In the past seven days, did you need help with any of these daily activities? *(Check all that apply)*

- ☐ Bathing
- ☐ Eating
- ☐ Getting dressed
- ☐ Grooming
- ☐ Preparing food
- ☐ Using the toilet
- ☐ Walking
- ☐ Taking or organizing medications
- ☐ Other: _____

Do you have any of the following health conditions?

- ☐ Congestive Heart Failure *(CHF)*
- ☐ Chronic Obstructive Pulmonary Disease *(COPD)*
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Hepatitis C
- ☐ High Risk Pregnancy
- ☐ Pregnancy
- ☐ Tuberculosis HIV/AIDs
- ☐ Other: _____

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Compared to 1 year ago, how would you rate your physical health in general?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

Medication Needs:

Would you like help with your medications?

- ☐ Yes
- ☐ No, I decline

Do you have trouble taking your daily medications or would you like help with medication concerns?

- ☐ Yes
- ☐ No

Do you have any of the following medication concerns?

- ☐ Cost
- ☐ Side effects
- ☐ Too many medications
- ☐ Trouble understanding the directions
- ☐ When to take them

Behavioral Health Needs:

Compared to 1 year ago, how would you rate your emotional health?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

Would you like to be screened for behavioral health and receive help with your mental health?

- ☐ Yes
- ☐ No
- ☐ Usure
- ☐ Decline to answer

Do you have any of the following conditions? *(Check all that apply)*

- ☐ Bipolar
- ☐ Borderline Personality Disorder
- ☐ Eating Disorder
- ☐ Intellectual and/or Developmental Disability
- ☐ Major Depressive Disorder
- ☐ Post-Traumatic Stress Disorder
- ☐ Schizophrenia
- ☐ Substance-Use Disorder
- ☐ Other: _____

Would you like help with an intellectual and/or developmental disability?

- ☐ Yes
- ☐ No
- ☐ Usure
- ☐ Decline to answer

Would you like help with your substance use?

- ☐ Yes
- ☐ No
- ☐ Usure
- ☐ Decline to answer

Do you use tobacco products? *(cigarettes, chew, snuff, pipes, cigars, vapor cigarettes)*

- ☐ Yes
- ☐ No
- ☐ Decline to answer

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