**Health Risk Assessment Screening**

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| **Member Information** | | |
| **First and Last Name** | **Member ID** | **DOB** |
| **Mailing Address** | **Phone Number** | **Email Address** |
| **Personal Characteristics** | | |
| 1. **Would you like to receive email or text communication from us?**  Yes  No  Don’t know | | |
| 1. **How tall are you?** | | |
| 1. **How much do you weigh?** | | |
| 1. **Do you need an interpreter to communicate with us do you need notices in another format?**   Yes  No  Don’t know | | |
| 1. **Do you need a sign language interpreter to communicate with us?**   Yes (type needed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_  No  Don’t know | | |
| 1. **What is your preferred spoken language?**  English  Spanish  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 1. **What is your preferred written language?**  English  Spanish  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 1. **What is your gender? (check all that apply)**  Woman/Girl  Man/Boy  Non-binary   Agender/No Gender  Transgender  Questioning  Don’t Know  Not Listed. Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I don’t know what this question is asking  I don’t want to answer | | |
| 1. **How do you describe your sexual orientation or sexual identity? (check all that apply)** Same-gender loving  Same-sex loving  Lesbian  Gay  Bisexual  Pansexual  Asexual  Queer  Straight (attracted mainly to or only to other gender(s) or sex(es)  Questioning  Don’t know   Not listed. Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I don’t know what this question is asking  I don’t want to answer | | |
| 1. **What is your relationship status?** Single  Significant Other/Domestic Partner  Married  Widowed Separated  Divorced  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 1. **Which of the following describes your ethnic identity?**   Hispanic  Not Hispanic  Don’t know  Decline to answer | | |
| 1. **Which of the following describes your racial identity? (see next page)**  |  |  |  |  | | --- | --- | --- | --- | | **American Indian or Alaska Native**  American Indian  Alaska Native  Canadian Inuit, Metis,  or First Nation  Mexican Native or  Indio  Central American, or South American | **Asian**  Asian Indian  Chinese  Filipino/a  Laotian  Hmong  Japanese  Korean  South Asian  Vietnamese  Other Asian | **Native Hawaiian or Pacific Islander**  Guamanian or  Chamorro  Micronesian  Native Hawaiian  Samoan  Tongan  Other Pacific Islander | **Hispanic or Latino/a**  Hispanic or Latino/a  Central American  Hispanic or Latino/a  Mexican  Hispanic or Latino/a  South American  Other Hispanic or  Latino/a | | **White**  Eastern European  Slavic  Western European  Other | | **Black or African American**  African American  African (Black)  Caribbean (Black)  Other Black | **Other Categories**  Other (please list)    Don’t know  Decline to answer | | **Middle Eastern/ North African**  North African  Middle Eastern | | | |
| **Family and Home** | | |
| 1. **Are you currently pregnant?**  Yes  No **If yes, when are you due?** Due Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. **Have you been told your pregnancy is “high risk?”**  Yes  No | | |
| 1. **Have you been discharged from the armed forces of the United States?**  Yes  No  Don’t know Decline to answer | | |
| 1. **Are you or is your close family a veteran?**  Yes  No  Don’t know  Decline to answer | | |
| 1. **Are you a refugee?**  Yes  No  Don’t know Decline to answer | | |
| 1. **In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.**   Food  Clothing  Utilities  Phone  Medicine Child Care  Vision  Housing  Medical care  Dental care  Mental Health care  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 1. **Do you need help with any of these daily activities?**   Eating  Getting dressed  Grooming  Bathing  Using the toilet  Taking or organizing medications  Preparing food  Walking  Falling often | | |
| 1. **Do you live in one of the following locations?**   Nursing home  Assisted living home  Behavioral health home  None of these | | |
| 1. **What is your housing situation?**   I have housing  I do not have housing (staying with others, hotel, shelter, living outside, in a car, or in a park) | | |
| 1. **Are you worried about losing your housing?**  Yes  No | | |
| 1. **How many family members, including yourself, do you currently live with?** (write number):\_\_\_\_ | | |
| 1. **YOUTH ONLY: Has DHS Child Welfare been involved with your family?**   Yes  No   **Please explain** : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 1. **YOUTH ONLY: What is your child’s current living arrangement?**  Parent(s)/guardian  DHS  Foster home  Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 1. **YOUTH ONLY: Was your child exposed to drug or alcohol during pregnancy?**   Yes  No Decline to answer | | |
| 1. **YOUTH ONLY: Does your child show signs of social, emotional, or behavioral problems?**  Yes  No Decline to answer | | |
| 1. **YOUTH ONLY: Has your child been diagnosed with any of the following: anxiety disorders, conduct disorders, obsessive-compulsive disorder, psychotic disorder; bipolar disorder?**   Yes  No Decline to answer | | |
| 1. **YOUTH ONLY: Is your child currently attending school?**   Yes  No Decline to answer | | |
| **Money and Resources** | | |
| 1. **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 needs, work, or appointments  No | | |
| 1. **What is the highest level of school that you have finished?**   Less than high school  High school diploma/GED  More than high school | | |
| 1. **What is your current work situation?**   Part-time or temporary work  Full-time work  Unemployed  Unemployed but not seeking work (student, retired, disabled, unpaid care giver)  Other (please explain): | | |
| 1. **At any point in the past 2 years, has seasonal or migrant farm work been your or your family’s main source of**   **income?**  Yes  No Decline to answer | | |
| 1. **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.** (write amount): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 1. **What is your main health insurance?**   None/Uninsured  Medicaid (UHA/OHP)  VA  Other Public Insurance (CHIP)  Private Insurance  Medicare Medicare Advantage  Other Public Insurance (not CHIP) | | |
| 1. **In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile**   **correction facility?**  Yes  No Decline to answer | | |
| **Social and Emotional Health** | | |
| 1. **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  A little bit  Somewhat  Quite a bit  Very much | | |
| 1. **How often do you see or talk to people that you care about and feel close to? (For example: talking to friends 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+ times a week | | |
| 1. **Do you feel physically and emotionally safe where you currently live?**  Yes  No  Don’t know | | |
| 1. **In the past year, have you been afraid of your partner or ex-partner?**  Yes  No  Don’t know | | |
| 1. **Are there any cultural, religious, or spiritual beliefs or practices that may influence your care? If yes, please explain:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Medical and Dental** | | |
| 1. **Who is your Primary care provider? Date of last visit?** | | |
| 1. **Who is your Oral health provider/Dentist? Date of last visit?** | | |
| 1. **Do you have one of these disabilities?**  Hard of hearing  Deaf  Blind  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 1. **Do you see your dental provider every 6 months for routine care?**  Yes  No | | |
| 1. **Do you have high health needs or medical issues?**   No  Yes (please explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 1. **Do you use tobacco products (cigarettes, chew, snuff, pipes, cigars, vapor cigarettes)?**  Yes  No | | |
| 1. **Do you have any health concerns you need help with?**   No  Yes (please explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 1. **Do you have any of the following?**   Congestive Heart Failure (CHF)  Hepatitis C  Heart Disease  Diabetes  Chronic Obstructive Pulmonary Disease (COPD)  Tuberculosis HIV/AIDs  Other (please explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Medications** | | |
| 1. **Do you have trouble taking your daily medications?**  Yes  No | | |
| 1. **If yes, is it due to side effects, the cost, trouble understanding the directions or when to take them?**  Yes  No | | |
| 1. **Would you like help with your medication concerns?**  Yes  No | | |
| **Behavioral Health** | | |
| 1. **Do you have a substance use disorder?**  Yes  No  Decline to answer | | |
| 1. **If yes, what do you use?** Alcohol  Methamphetamines  Cocaine  Heroin  Fentanyl Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **How do you use it?** Ingest (swallow) Smoke Snort Inject | | |
| 1. **Are you on any medication assisted treatment (Methadone, Buprenorphine) for Opiate Use Disorder?**  Yes  No Decline to answer | | |
| 1. **Do you want help with drug use?**  Yes  No **If yes, would you like help with medication assisted therapy for opiate use?**  Yes  No | | |
| 1. **Do you have a mental illness?**  Yes  No Decline to answer | | |
| 1. **Do you have a family history of mood disorders, psychotic disorders, or schizophrenia?**   Yes  No Decline to answer | | |
| 1. **Do you ever experience any of the following: Hearing, seeing, tasting, or believing things that others don’t, persistent unusual thoughts or beliefs that can’t be set aside regardless of what others believe, strong and inappropriate emotions or no emotions at all?**   Yes  No Decline to answer | | |
| 1. **Do you have a developmental disability, or have you ever been diagnosed with the following: autism, brain injury, cerebral palsy, Down syndrome, fetal alcohol syndrome, spina bifida, or intellectual disability?**   Yes  No Decline to answer | | |
| 1. **Do you want help managing your mental health needs?**  Yes  No | | |

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