**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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