Valley Community Healthcare

Patient Label:

Health Risk Assessment

If you are unsure about any terms, feel free to ask for help. The numbers next to some of the answers are there to help VCH personnel record your answers accurately in your electronic healthcare record.

Name: _____ Current Date: _____

Member #: _____ Date of Birth: _____ Phone #: (__) ___-_____

Address: _____ City, State: _____ Zip Code: _____

Please mark "yes" or "no", or fill in requested information as appropriate. Write "NA" if not applicable.

GETTING TO KNOW YOU

Are you able to read? ◯ No ◯ Yes Are you able to write? ◯ No ◯ Yes

What language do you prefer to speak? ◯ English = 0 ◯ Another Language: _____ (= 2)

What language do you prefer to read? ◯ English = 0 ◯ Another Language: _____ (= 2)

What language do you prefer to write? ◯ English = 0 ◯ Another Language: _____ (= 2)

What language are you most fluent in? _____

What culture(s) do you identify with most? _____

Making Healthcare Decisions:

Are you usually the main decision-maker regarding your healthcare? ◯ No = 1 ◯ Yes = 3

Would you like information about receiving medical benefits? ◯ No = 3 ◯ Yes = 1

Would you like information on wellness education programs? ◯ No = 4 ◯ Yes = 1

Many of our clients ask trusted family members or others to make healthcare decisions for them.

If you normally receive assistance, who do you ask to help you decide, or to make a decision for you?

◯ Spouse/Partner = 2 ◯ Adult Child (Daughter/Son) = 3 ◯ Adult Sibling (Sister/Brother) = 4

◯ Other Friend/Relative: _____ (= 5) ◯ Other: _____

Advance Directives:

An Advance Directive is similar to a "Power of Attorney". It allows you to choose someone you trust to make health decisions for you if you cannot due to illness or injury. There is also space to write your healthcare wishes in your own words, ensuring your priorities and values are respected by your agent and doctors.

Do you have an Advance Directive for your healthcare, or a living will? ◯ No = 3 ◯ Yes = 1

(If you have one, please bring a copy to the clinic so we can place it in your record.)

Would you like to receive information regarding Advance Directives? ◯ No = 4 ◯ Yes = 1

Quality of Life:

Of the following, please choose which word best fits how you view your own health currently:

◯ Excellent = 0 ◯ Very Good = 1 ◯ Good = 2 ◯ Fair = 3 ◯ Poor = 4

At VCH we want to improve every aspect of patient health, including your quality of life. Everyone has different priorities, so your ideal quality of life is unique to you. Priorities may include improving your personal comfort, maintaining your ability to pursue your goals, striving for overall emotional fulfillment, or other factors.

Do you feel satisfied with your current quality of life? ◯ No ◯ In some ways ◯ In many ways ◯ Yes

YOUR CURRENT HEALTH & LIFESTYLE

What do you usually do to keep yourself feeling healthy?

◯ I visit my doctor annually, even when I am feeling well. ◯ I exercise safely and regularly.
◯ I visit my doctor when I do not feel well. ◯ I have a healthy diet and eat regularly.
◯ I take vitamins and/or calcium supplements. ◯ I drink a healthy amount of water daily.
◯ I do these other activities: _____

There are many kinds of health treatments and practices; please mark any of the following you use:

◯ Coining = 1 ◯ Rubbing = 1 ◯ Massage = 1 ◯ Acupuncture = 3 ◯ Traditional Healers = 3
◯ Cupping = 1 ◯ Pinching = 2 ◯ Herbs = 2 ◯ Chiropractic = 4 ◯ Other: _____

What is your height? _____ *(in inches, please)* What is your weight? _____ *(in pounds, please)*

Do you drink alcohol? ◯ No ◯ Yes How many drinks? _____ How often? _____

Do you smoke cigarettes? ◯ No ◯ Yes How many (cigarettes / packs) a day? _____ *(circle one)*

Are you exposed to secondhand smoke? *(ex., coworkers or family members who smoke around you)* ◯ No ◯ Yes

Is anyone hurting or threatening you? ◯ No ◯ Yes ◯ Decline to indicate on this form.

Have you been physically, emotionally or sexually abused, or forced to have sex? ◯ No ◯ Yes ◯ Decline

YOUR HOME ENVIRONMENT

Do you live alone? ◯ No = 0 ◯ Yes = 5 Do you have stairs inside your home? ◯ No = 0 ◯ Yes = 5

Do you have to go up or down stairs to enter your home or apartment complex? ◯ No = 0 ◯ Yes = 5

Do you live in: ◯ Home you own = 0 ◯ Home you rent = 2 ◯ Board & care = 3
◯ Senior housing complex = 4 ◯ Nursing home = 5 ◯ Other, describe: _____ (= 1)

Do you take care of anyone in your household? *(Children, dependent adults, elderly adults, etc.)* ◯ No = 0 ◯ Yes = 3

Do you have family, friends or others to help at home if you become sick/disabled? ◯ No = 5 ◯ Yes = 0

If you will need assistance, do you know anyone who would be available to help you?

Name: _____ Relationship: _____ Phone: (__) ___ - ____

Address: _____ City, State: _____ Zip Code: _____

Do you have a caretaker? ◯ No ◯ Yes If so, does your caretaker receive payments? ◯ No ◯ Yes

Do you have transportation to your doctor? ◯ No ◯ Yes If so, what is your transportation? _____

DAY-TO-DAY TASKS & ASSISTANCE

When accomplishing tasks at home, sometimes you may find yourself in need of assistance from a person or an assistive device (like a reach extender or cane). Please use the following chart to describe your current home routine by circling how much assistance, if any, you use to complete the following tasks:

Activity:	I = No Assistance Needed	A = Some Assistance Needed	D = Total Assistance Need
Bathing:	I	A	D
Hygiene:	I	A	D
House Cleaning:	I	A	D
Preparing Meals:	I	A	D

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DAY-TO-DAY TASKS & ASSISTANCE, CONTINUED

Some day-to-day tasks are more complex or difficult to accomplish alone. Indicate below if you believe your current health status would limit you from engaging in any of the following activities:

Moving a table: ◯ No ◯ Yes
Using a vacuum cleaner: ◯ No ◯ Yes
Playing golf: ◯ No ◯ Yes
Climbing stairs: ◯ No ◯ Yes

Comments: _____

_____

YOUR MEDICAL HISTORY

When was the last time you saw your primary doctor? _____
When is your next doctor appointment? _____
In the last 6 months, how many times did you visit your doctor? _____
Are you currently seeing a specialist? ◯ No ◯ Yes If so: Type of Specialist: _____
Name of Specialist: _____
Phone Number: _____

In the last 12 months, how many times did you require emergency room services?
◯ None = 0 ◯ One = 2 ◯ Two or More = 4
For what reason(s) did you visit the emergency room? _____

In the last 12 months, how many times were you hospitalized?
◯ None = 0 ◯ One = 2 ◯ Two or More = 4
For what reason(s) were you hospitalized? _____

During the last 12 months have you been treated for:
◯ Cancer = 4 ◯ Heart Disease = 3 ◯ Breathing Difficulties = 5
◯ Diabetes = 4 ◯ Blindness = 4 ◯ High Blood Pressure = 2

Are you currently undergoing treatment for cancer? *(Radiation Therapy/Chemotherapy)* ◯ No ◯ Yes

ASSISTIVE EQUIPMENT

Mark any of the following medical equipment that is in your home and mark if you own or rent the equipment.

Own:	Rent:	Equipment:	Own:	Rent:	Equipment:
◯	◯	Cane	◯	◯	Portable Commode
◯	◯	Crutches	◯	◯	Hospital/Adjustable Bed
◯	◯	Walker	◯	◯	Oxygen Tank
◯	◯	Wheelchair	◯	◯	Other: _____

Please indicate what type of medical equipment you currently use regularly:
◯ None = 0 ◯ Cane = 0 ◯ Crutches = 3 ◯ Walker = 3 ◯ Wheelchair = 5
◯ Hearing Aide = 1 ◯ Portable Commode = 4 ◯ Oxygen Tank = 5 ◯ Hospital Bed at Home = 5

MEDICATION					
How many prescribed medications do you take on a regular basis? Circle one of the following:					
Zero (0)	One (1)	Two (2)	Three (3)	Four (4)	Five (5)
Six (6)	Seven (7)	Eight (8)	Nine (9)	Ten (10)	More than Ten

Please list all prescription & over-the-counter medications you use currently. *(Include herbal supplements & vitamins)*

Medication Name	What condition are you taking this medication for?	How long have you been taking it?	Have you had any problems with this medication?

For Office Use:					
Zero (0) Med = 0	One (1) Med = 1	Two (2) Med = 1	Three (3) Med = 2	Four (4) Med = 2	Five (5) Med = 3
Six (6) Med = 3	Seven (7) Med = 4	Eight (8) Med = 4	Nine (9) Med = 5	Ten (10) Med = 5	More than Ten