

Enrollees with Special Health Care Needs

Adult Health Risk Assessment

Member Name: _____

Date form filled out: _____

Date of Birth: _____

Sex: Female Male

1. Do you currently need or use **medicine prescribed by a doctor** for ANY medical, behavioral or other health condition?

Yes ⇒ Go to Question 1a

No ⇒ Go to Question 2

1a. Is this a condition that has lasted or is expected to last for **at least** twelve months?

Yes

No

2. Do you need or use **more medical care or mental health services** than is usual for someone of your age for ANY medical, behavioral or other health condition?

Yes ⇒ Go to Question 2a

No ⇒ Go to Question 3

2a. Is this a condition that has lasted or is expected to last for **at least** twelve months?

Yes

No

3. Are you **limited or prevented** in any way from doing the things most people of the same age can do because of ANY medical, behavioral or other health condition?

Yes ⇒ Go to Question 3a

No ⇒ Go to Question 4

3a. Is this a condition that has lasted or is expected to last for **at least** twelve months?

Yes

No

4. Do you need or get **special therapy**, such as physical, occupational or speech therapy because of ANY medical, behavioral or other health condition?

Yes ⇒ Go to Question 4a

No ⇒ Go to Question 5

4a. Is this a condition that has lasted or is expected to last for **at least** twelve months?

Yes

No

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5. Do you have any kind of emotional or behavioral problem for which you need or get **treatment or counseling**?

- Yes ⇒ Go to Question 5a
 No ⇒ Go to Question 6

5a. Has this problem lasted or is it expected to last for at least 12 (twelve) months?

- Yes
 No

6. Are you pregnant?

- Yes ⇒ Please call Community Health Plan at 1-800-440-1561 and ask to speak with the New Arrivals Program.
 No ⇒ Go to Question 7

7. On a scale of 1-5, how much pain are you experiencing today?

(No pain at all) 1 ---- 2 ---- 3 ---- 4 ---- 5 (a lot of pain)

8. On a scale of 1-5, how comfortable are you contacting your doctor if you are experiencing pain or discomfort?

(Very comfortable) 1 ---- 2 ---- 3 ---- 4 ---- 5 (not comfortable at all)

9. Who is the doctor that you see the most? _____

10. Do you know your blood pressure?

- Yes - What is it usually? _____
 No

11. Do you use a cane, walker, wheel chair, or other medical equipment?

- Yes If YES, Do you have stairs where you live? YES NO
 No

12. On a scale of 1-5, how well do you think your conditions are being treated?

(Very well) 1 ---- 2 ---- 3 ---- 4 ---- 5 (not well at all)

13. Do you live by yourself or with other people?

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14. In the past few weeks:

A) In the past few weeks, how have you been feeling physically and emotionally?

B) On a scale of 1-5, how has your condition affected your work or school?

(Not affected at all) 1 ---- 2 ---- 3 ---- 4---- 5 (severely affected)

C) On a scale of 1-5 how has your condition affected your leisure time/social life?
(For example going to church, going out with friends)

(Not affected at all) 1 ---- 2 ---- 3 ---- 4---- 5 (severely affected)

15. About your doctor:

A) Do you and your doctor talk about your plan for care?

Yes

No - Why not? _____

B) On a scale of 1-5, how satisfied are you with your plan for care?

(Very satisfied) 1 ---- 2 ---- 3 ---- 4 ---- 5 (very unsatisfied)

C) On a scale of 1-5, do you feel you participated with your doctor in making your plan for care?

(A lot) 1 ---- 2 ---- 3 ---- 4 ---- 5 (not at all)

16. Do you have special therapy, or community services (other agency) help at home?

Yes - With whom? _____

No

17. Is it alright if we talk with your doctor about this information?

Yes

No - Why not? _____

18. Is there anything else we can help you with?

YES Please explain: _____

NO