Saltzer HEALTH

Wellness Health Risk Assessment

Please bring all medication bottles with you to your appointment

Patient Name: _____ DOB: _____ Date Completed: _____

1. Do you need help with any of the following activities?

- ☐ No help needed
- ☐ Shopping for groceries or clothes
- ☐ Preparing food or meals
- ☐ Taking your medication
- ☐ Bathing yourself
- ☐ Doing housework
- ☐ Getting dressed
- ☐ Managing money
- ☐ Using the toilet

2. Do you have problems with your memory, or does your family state you are having problems remembering things?

☐ Yes ☐ No

3. Which of the following safety features does your home have?

- ☐ Stairway handrails
- ☐ Smoke detectors
- ☐ Grab bars in the bathroom
- ☐ Adequate lighting

4. Have you lost interest or pleasure in doing things?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day
- ☐ Declined to specify

5. Have you felt down, depressed or hopeless?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day
- ☐ Declined to specify

6. Have you had any falls in the past year?

☐ Yes ☐ No

7. Do you have a Living Will or Medical Power of Attorney?

☐ Yes ☐ No

8. Do you have any of the following communication barriers?

- ☐ None
- ☐ Difficult reading
- ☐ Difficulty writing
- ☐ Difficulty speaking
- ☐ Sign language
- ☐ Hearing impaired
- ☐ Deaf
- ☐ Vision impaired
- ☐ Blind

9. During the past 4 weeks, how would you rate your health, in general?

- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

10. Which of the following applies to you?

- ☐ I have a supportive family
- ☐ I have supportive friends
- ☐ I participate in church, clubs or other group activities
- ☐ I don't have a support system

11. How many days per week do you exercise?

- ☐ 1-3 days
- ☐ 4-5 days
- ☐ 6-7 days

12. How often do you follow a healthy diet including fruits, vegetables, good protein, whole grains?

- ☐ Always
- ☐ Often
- ☐ Occasionally
- ☐ Almost Never

13. In the last year, did you ever eat less than you felt like you should because there wasn't enough money for food?

- ☐ Frequently
- ☐ Occasionally
- ☐ Rarely
- ☐ Never

14. How many visits to the ER or hospital stays have you had in the past 12 months?

- ☐ 0
- ☐ 1-2
- ☐ 3+

15. In the past 12 months, have you been unable to afford to pick up a prescribed medication?

- ☐ Yes
- ☐ No

16. What is the highest level of school you have finished?

- ☐ Less than high School
- ☐ High school degree or equivalent
- ☐ Some college, no degree
- ☐ College degree or beyond

17. What Durable Medical Equipment (DME) do you use?

☐ None

☐ Cane ☐ Walker ☐ Wheelchair ☐ Oxygen ☐ Nebulizer ☐ CPAP/VPAP

18. Are you on Home Health?

- ☐ Yes
- ☐ No

Please list agency: _____

19. What other providers or specialists do you see? (Please include name and specialty)

_____ _____

_____ _____