Health Risk Assessment

[Default->Today's Date]

Patient Name: [Patient->Full Name] Patient DOB: [Patient->Date Of Birth]

1. In the past 7 days, how many days did you exercise?

_____ days ☐ not currently exercising (go to question 4)

2. On days when you exercised, for how long did you exercise (in minutes)?

_____ minutes

3. How intense was your typical exercise?

☐ light	☐ moderate	☐ heavy	☐ very heavy
(stretching, slow walk)	(brisk walk)	(jog, swim)	(fast run, stair climb)

4. In the past 7 days how many servings of fruits and vegetables did you typically eat each day?

_____ servings per day

5. In the past 7 days how many servings of high fiber or whole grain foods did you eat each day?

_____ servings per day

6. In the past 7 days how many servings of fried or high fat foods did you eat each day?

_____ servings per day

7. In the past 7 days how many sugar sweetened (not diet) beverages did you drink each day?

_____ beverages per day

8. In the past 2 weeks, how often have you felt down, depressed, or hopeless?

☐ all the time ☐most of the time ☐ some of the time ☐ almost never

9. In the past 2 weeks, how often have you felt little interest or pleasure in doing things?

☐ all the time ☐ most of the time ☐ some of the time ☐ almost never

10. Have your feelings caused you distress or interfered with your ability to get along with others?

☐ yes ☐ no

11. In the past two weeks, have you felt nervous, anxious or on edge?

☐ all the time ☐ most of the time ☐ some of the time ☐ almost never

12. In the past two weeks how often were you unable to stop worrying or control worrying?

☐ all the time ☐ most of the time ☐ some of the time ☐ almost never

13. How often is stress a problem for you in handling your: health, finances, relationships, work?

☐ all the time ☐ most of the time ☐ some of the time ☐ almost never

14. How often do you get the social or emotional support you need?

☐ always ☐ usually ☐ sometimes ☐ rarely ☐ never

15. In the past 7 days, how much pain have you felt?

☐ a lot ☐ some ☐ none

16. In general, would you say your health is:

☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

17. How would you describe the condition of your mouth and teeth?

☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

18. In the past 7 days, did you need help from others to perform activities such as eating, dressing grooming, bathing, walking or using the toilet?

☐ yes ☐ no

19. In the past 7 days did you need help from others to take care of things such as laundry, house keeping, banking, shopping, cooking, transportation, or taking medications?

☐ yes ☐ no

20. Each night, how many hours of sleep do you get?

_____ Hours

21. Do you snore or has anyone told you that you snore?

☐ yes ☐ no

22. In the past 7 days, how often have you felt sleepy during the daytime?

☐ always ☐ usually ☐ sometimes ☐ rarely ☐ never

23. In the past 30 days have you smoked tobacco?

☐ yes ☐ no

24. In the past 30 days have you used smokeless tobacco?

☐ yes ☐ no

25. If you answered yes to either of the above, would you be interested in quitting?

☐ yes ☐ no

26. In the past 7 days, how many days did you drink alcohol?

_____ days

27. Do you drink more than 4 alcoholic drinks on one occasion?

☐ 3-7 times a week ☐ 2-3 times a week ☐ once a week ☐ never

28. Do you ever drive after drinking or ride with a driver who has been drinking?

☐ yes ☐ no

29. Do you always fasten your seat belt when you are in a car?

☐ yes ☐ no