HEALTH RISK ASSESSMENT FORM

Dear Member:

A Health Risk assessment is a short survey that helps Astiva Health know more about your health status and meet your needs better. We value the trust you have in us and take every measure to protect your privacy. The information collected in this form will be used to develop an Individualized Care Plan (ICP), which will be shared only with you and your primary care provider. We are grateful for the time and attention you put into answering every question on this form. Please return the completed form by fax at (714) 908-8055, by e-mail at AstivaUMDept@astivahealth.com, or by mail to: HRA UM Dept., 765 The City Dr. Suite 200, Orange, CA 92868

Sincerely,
Your Astiva Health Care Management Team

Member Personal Information and Preferences			
First Name:	Middle Initial:	Last Name:	Sex at birth: ❑ Male ❑Female
Date of Birth:	Best number to contact:	Age:	Email:
❑ I agree to proceed with completing this form		❑ I decline to complete this form	

1. Gender Identity: ❑ Male ❑Female ❑Nonbinary ❑Transexual Male ❑Transexual Female ❑Decline
2. What is your sexual orientation? (Who you are attracted to)

❑ Straight or heterosexual ❑ Bisexual ❑ Lesbian, gay, or homosexual ❑ Other ❑ Decline

3. What language do you prefer to speak? ❑ Decline ❑Other_____

❑ English ❑Vietnamese ❑ Spanish ❑ Korean ❑ Mandarin ❑Cantonese ❑ Taiwanese

4. What ethnicity do you identify as? ❑ White/Caucasian ❑Asian ❑ Hispanic/Latino

❑ African American/Black ❑ American Indian/Alaska Native ❑ Pacific Islander ❑ Middle Easters

❑ Mixed ❑ Other ❑ Decline

5. Do you have access to a smart phone or tablet for use? ❑ Yes ❑ No ❑ Decline
6. Would you be open to telephonic outreach by a care manager? ❑ Yes ❑ No ❑ Unsure
7. Do you have an updated Advance Care Planning, which is a document that captures your preferences for health care and end-of-life wishes? ❑ Yes ❑ No ❑ Unsure ❑ Decline

Chronic Disease Conditions (*Please mark each condition that applies to you.*)

8. What health conditions do you currently have?

❑ Asthma

❑ COPD, Asthma, or breathing/lung conditions

❑ Heart disease

❑ Heart failure

❑ High blood pressure

❑ Severe Obesity

❑ Malnutrition or unintentional weight loss

❑ Decline to respond

❑ Kidney disease or kidney failure

❑ Diabetes or high blood sugar

❑ Cancer

❑ HIV or AIDS

❑ Behavioral or mental health conditions

❑ Alzheimer's Disease or other dementia

❑ Parkinson's or other neurodegenerative diseases

❑ Other

❑ History of stroke

General Health Survey

9. Compared to other people your age, how would you describe your health?

❑Excellent ❑ Good ❑ Fair ❑ Poor ❑ Decline

10. Do you normally experience pain? ❑ Yes ❑ No ❑ Decline

11. What is your average level of pain? ❑ 0-3(minimal) ❑4-5 (moderate) ❑ 6-7 (severe) ❑ 8-10 (unbearable)

12. How are you managing your pain (select all that apply)? ❑ Prescription ❑ Over the Counter

❑ Exercise ❑ Physical Therapy ❑ Alternative Therapy ❑ Rest ❑ No Treatment ❑ Other

13. Do you use any medical equipment or medical devices? ❑ Yes (pick all that applies) ❑ No ❑ Decline

❑ Cane ❑ Walker ❑ Wheelchair ❑ Electric Wheelchair/ Scooter ❑ Oxygen ❑ CPAP/BiPAP ❑ Hospital Bed

14. In the past year, how many times have you been to the emergency room? ❑ 0 ❑1 ❑ 2 ❑ ≥ 3

15. How many prescription medications do you take? Please attach a separate medication list.

❑ 0-3 ❑ 4-7 ❑ 8-10 ❑ >10

16. Is there anything that prevents you from taking medications as prescribed (select all that apply)?

❑Scheduling ❑Cost

❑Side Effects ❑Visual Problems

❑Transportation/Access ❑I don't believe in medications

❑Not sure how to take ❑Difficulty filling prescriptions

❑Forgetfulness ❑No system for managing

❑Other ❑Nothing

Mental and Emotional Health

17. Over the past month, how often have you been bothered by the following:	Not at all	Several days	Daily	Decline to answer
a. Little interest or pleasure in doing things	❑	❑	❑	❑
b. Feeling down, depressed, or hopeless	❑	❑	❑	❑

18. Have you noticed difficulty or a change in your ability to remember, concentrate, or make decisions?	❑Yes	❑ No	❑ Unsure	❑ Decline

Functional Assessment

19. How often do you need help for these tasks: ❑ Decline to respond	Never	Rarely	Sometimes	Always
a. Using the toilet	❑	❑	❑	❑
b. Walking or getting around	❑	❑	❑	❑
c. Feeding yourself	❑	❑	❑	❑
d. Grooming yourself	❑	❑	❑	❑
e. Bathing yourself	❑	❑	❑	❑
f. Dressing yourself	❑	❑	❑	❑
g. Using the phone to make appointments	❑	❑	❑	❑
h. Doing your laundry, shopping, meal prep	❑	❑	❑	❑
i. Managing your medications	❑	❑	❑	❑

20. In the last 30 days, how many times have you done some form of exercise for at least 30 minutes? ❑ Decline to respond	❑0	❑1-2	❑3-4	❑≥5
21. In the last 12 months, how many times did you sustain a fall to the ground? ❑ Decline to respond	❑0	❑1	❑2	❑>3

Social Health History

22. How often do you feel lonely or isolated from those around you? ❑ Decline to respond
❑ Never ❑ Rarely ❑ Sometimes ❑ Often ❑ Always
23. Do you have the support you need to keep you safe and independent at home? ❑ Decline to respond
❑ Always ❑ Mostly ❑ Sometimes ❑ Rarely ❑ Never
24. Are you worried about losing your housing? ❑ Yes ❑ No ❑ Decline to respond
25. Within the past 12 months, did you worry that your food would run out before you got money to buy more? ❑ Yes ❑ No ❑ Decline to respond
26. Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need?
❑Yes ❑No
27. What best describes your current living arrangement?
❑ Live alone ❑ Live with family or significant other ❑ Live with others, not family
❑ Live with caregiver ❑ Live in an assisted living facility or nursing home
28. Are you afraid of anyone or is anyone hurting you? ❑ No ❑ Decline ❑ Yes (explain)
29. Do you currently smoke? ❑ Yes ❑ No ❑ Decline
    a. If yes, are you open to counseling and treatment to help you stop smoking? ❑ Yes ❑ No
30. How many times in the past 12 months have you had more than 4-5 drinks in a day? ❑ Decline
❑ Never ❑ 1-2 times ❑ Once a month ❑ Once a week ❑ Daily or almost daily
31. How many times in the past 12 months have you used (non-prescription) drugs? ❑ Decline
❑ Never ❑ 1-2 times ❑ Once a month ❑ Once a week ❑ Daily or almost

Additional Comments:

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Who helped to complete the form (if not the member):	Relationship to the member (if not the member):
Date of completion:	Signature of the member: