Risk Assessment

Name: _____

Date of Birth: _____

Please Circle

1. Is there anyone else involved in your health care decisions?

Alone Spouse/Partner Family Member/Friend

Paid Caregiver Independent Living/Senior Housing

Assisted living Nursing Home Facility

2. What is your current living arrangement?

Alone Spouse/Partner Family Member/Friend

Paid Caregiver Independent Living/Senior Housing

Assisted living Nursing Home Facility

3a. Physical Characteristics: Hearing

Good Fair Poor Good with Hearing Aid

3b. Physical Characteristics: Vision

Good Fair Poor Good with Glasses

4. Do you use any of the following special equipment?

Hospital bed Hoyer life Grab bars Bedside commode

Wheelchair Cane Walker Other None

5. Do you receive any of the following special treatments?

Tube feeding Tracheostomy care Ostomy care Wound Caregiver Dialysis

Chemotheraphy Oxygen CPAP Insulin pump Nebulizer None

6. Have you completed a Living Will, Advanced Directives or other Health Care wishes documents? If yes please bring a copy with you to your appointment.

Yes No I don't know

7. In general how do you rate your overall health?

Excellent Good Fair Poor

8. How many medications (prescription medications and over the counter) do you take on a regular basis?

None 1-4 5-9 10+

9. Do you currently see 3 or more doctors on a regular basis? Please bring a list of doctors seen with you to your appointment.

Yes No

10. Alcohol use:

Yes No

How many drinks per day? _____

How many drinks per week? _____

11. How often do you use prescription medication other than how it was prescribed?

Never Sometimes Often

12. Do you use recreational or illegal drugs?

Never Sometimes Often

13. In the last 30 days have you used Tobacco?

Smoked yes Smoked no Smokeless yes Smokeless no

If you have recently used tobacco, are you interested in quitting?

Yes No

14. In the last 7 days, how many days did you exercise, such as a brisk walk, for at least 20 minutes?

1 2 3 4 5 6+

I did not exercise

15. Have you seen an eye doctor?

Yes No

How often? _____

Name of doctor? _____

16. Have you seen a dentist?

Yes No

How often? _____

Name of dentist? _____

17. How much difficulty do you have:

Taking medications?	Not difficult	Some difficulty	Can not do at all
Managing money?	Not difficult	Some difficulty	Can not do at all
Preparing meals?	Not difficult	Some difficulty	Can not do at all
Shopping for groceries?	Not difficult	Some difficulty	Can not do at all
Doing routine household chores?	Not difficult	Some difficulty	Can not do at all

If you have difficulty with any of the above, does anyone help you with these tasks?

Yes No

18. Do you have any special language or cultural needs?

Yes No

19. Are you a caregiver for someone else?

Yes No

if yes, for who? _____

20. Do you have a caregiver who provides you with any assistance?

Yes No

if yes, who is your caregiver? _____

21. In the past 6 months, how many times have you:

Visited a Doctors office or Clinic? _____

Gone to an Emergency room or Urgent Care? _____

Stayed overnight in a Hospital? _____

22. Are you currently receiving any of the following services from an agency?

Visiting Nurse Social Worker Physical Therapy Speech Therapy

Home Health Aid Adult Day Care Center Home Delivery Medications

Homemaker/Chore Services None

23. Functional Capacities: Do you have any limitations?

Bathing Using Stairs Gripping Chores Work

Dressing Other None

24. Have you had any falls in the last year?

Yes No

If yes please list: _____

25. Home Safety. Do you have?

Smoke Alarms Grab bars Handrails on Stairs

Trip hazards such as Rugs in halls Poor Lighting None

26. Sleep assessment. Do you have troubles with?

Sleeping Snoring Apnea No issues sleeping

27. Are you following any special diet?

Yes No

28. Pain Management: How many days in the last week has pain interfered with daily activities?

1 2 3 4 5 6 7 None

29. Concerns with your bladder. Do any of the following apply?

Leak urine Leak urine when you cough or sneeze Leak urine when you bend or lift

Wear pads or briefs No concerns