ATRIO™
HEALTH PLANS

Health Risk Assessment

This assessment helps ATRIO Health Plans coordinate care specific to your needs. We encourage you to make copies for your personal health record and take to your healthcare provider to discuss further. Any information provided does not affect your enrollment.

Member name: _____

Date of birth: _____ **Gender:** Male ☐ Female ☐

Phone number: _____ **Mailing address:** _____

Preferred language: _____ **Race/ethnicity:**_____

This questionnaire is being completed by: Self ☐ Spouse/Partner ☐ Caretaker ☐ Other ☐

Primary Care Provider (Dr., P.A. or N.P.): _____

Height: _____(feet) _____(inches) **Weight in pounds:** _____

The following items are common activities you might do during a normal day. Circle one option for each group of activities.

Do you live in an adult foster home or assisted living facility?		YES	NO
1. Do you need help with shopping and meal preparation?		YES	NO
2. Do you need help with cleaning your home?		YES	NO
3. Do you need help with showering or dressing yourself?		YES	NO
4. Do you need help with getting up/down or in/out of chairs and bed?		YES	NO
5. Do you need assistance eating and/or drinking?		YES	NO
6. Do you have family or friends to help with your medical needs?		YES	NO
7. Have you fallen down in the past 12 months?		YES	NO
8. Have you been to your regular doctor in the last 12 months?		YES	NO
9. Has your doctor recommended you exercise more?		YES	NO
10. Do you smoke or use tobacco products?	YES	NO	I QUIT
11. Do you drink more than three (3) alcoholic drinks a day?		YES	NO
12. Do you use medications not prescribed, for recreational or illicit purposes?		YES	NO
13. Do you understand why nutrition is important for your health?		YES	NO
14. Have you completed an advanced directive for end of life decision making?		YES	NO

15. Do you take your medications as prescribed? YES NO

16. Did you receive an annual flu vaccination this year? YES NO

17. Did you had a pneumonia vaccination? YES NO

18. Have you been hospitalized or in the emergency room in the past 12 months? YES NO

    If yes, did you follow up with your primary care provider? YES NO

19. Have you noticed confusion or memory loss that is getting worse? YES NO

20. Have you had a mammogram within the last two (2) years? YES NO

21. Have you had a colonoscopy within the last five (5) years? YES NO

22. Have you had any of the following screenings within the last 12 months:

    a. Blood pressure YES NO

    b. Blood sugar YES NO

    c. Cholesterol YES NO

    d. Diabetic eye exam YES NO

23. What chronic health conditions do you have? Circle ‘yes’ or ‘no’ for each condition below:

    a. Alzheimer’s or Dementia YES NO

    b. Arthritis YES NO

    c. Asthma YES NO

    d. Cancer YES NO

    e. COPD YES NO

    f. Depression YES NO

    g. Diabetes YES NO

    h. Hearing loss YES NO

    i. Heart disease YES NO

    j. High blood pressure (Hypertension) YES NO

    k. High cholesterol YES NO

    l. Kidney disease or renal failure YES NO

m. Stroke YES NO

Please circle your answers to the following questions:

24. Would you say your overall **physical** health is: Excellent Good Fair Poor

25. On average, how many hours of sleep do you get a night? 0-3 4-6 7-10 More than 10

26. I feel my **daily stress level** is High Average Low

27. Compared to one year ago, how would you rate your health now? Better About the same Worse Unsure

28. Are you satisfied with your healthcare provider? Yes No I don't know who my provider is

29. Do you use any medical equipment or devices to assist you daily?

Walker Wheelchair Commode Shower

Bed Test Strips CPAP Other: _____

30. Any other comments you would like to make regarding your health, health care or future health needs?

_____

_____

_____

The responses to this assessment will allow a nurse to develop a care plan and assist in managing your care. If you would like assistance just return this form. If you would like to not be included in case management, please return this assessment, and consent to opting out of case management. You will receive another letter acknowledging your refusal and a follow-up in six months (per Center of Medicare and Medicaid Services, D-SNP regulation).

I opt out of case management: (signature): _____

Please use the self-addressed, stamped envelope provided to return this form by mail. You may also complete this over the phone by calling Customer Service at 1-877-672-8620. TTY Users can call 1-800-735-2900.