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 ☐

Name of Primary Care Doctor/Provider: _____

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.

1. Have you been to your regular doctor in the last 12 months?	YES	NO
2. Have you been to a dentist in the last 12 months?	YES	NO
3. Do you take your medications as prescribed?	YES	NO
4. Have you been hospitalized or in the emergency room in the past 12 months?	YES	NO
a. If yes, did you follow up with your primary care provider?	YES	NO
5. Have you fallen down in the past 12 months?	YES	NO
6. Has your doctor recommended you exercise more?	YES	NO
7. Do you live in an adult foster home or assisted living facility?	YES	NO
8. Do you need help with shopping and meal preparation?	YES	NO
9. Do you need help with cleaning your home?	YES	NO
10. Do you need help with showering or dressing yourself?	YES	NO
11. Do you need help with getting up/down or in/out of chairs and bed?	YES	NO
12. Do you need assistance eating and/or drinking?	YES	NO
13. Do you have family or friends to help with your medical needs?	YES	NO

14. Do you understand why nutrition is important for your health? YES NO

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

16. Do you smoke or use tobacco products? YES NO

17. Do you drink more than three (3) alcoholic drinks a day? YES NO

18. Do you use medications not prescribed, for recreational or illicit purposes? YES NO

19. Have you completed an advanced directive for end of life decision making? YES NO

20. 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

If yes, Type _____Year_____

e. COPD (lung disease) YES NO

f. Mental Health Condition YES NO

If yes, Type _____Provider_____

g. Diabetes YES NO

If yes, do you test your blood sugar daily? YES NO

Have you had an A1C test within the last six (6) months? YES NO

Have you had your annual Diabetic eye exam? YES NO

h. Hearing loss YES NO

i. Vision (Blind in one or both eyes or loss of vision YES NO

j. Heart disease (example: CHF, AFib, history of heart attack) YES NO

k. High blood pressure (hypertension) YES NO

l. High cholesterol YES NO

m. Kidney disease or renal failure YES NO

If yes, are you on dialysis? YES NO

n. Stroke YES NO

o. Developmental Disability YES NO

If yes, Type_____

21. Do you use any medical equipment or devices to assist you daily? YES NO

a. Walker/Cane YES NO

b. Wheel chair YES NO

c. Hospital bed YES NO

d. Test strips YES NO

e. Commode YES NO

f. Shower chair/rails YES NO

g. CPAP YES NO

h. Oxygen YES NO

i. Other:_____

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

23. Did you receive a pneumonia vaccination? YES NO

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

If yes, Year_____ Location_____

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

If yes, Year_____ Location_____

26. How is your overall physical health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

27. On average, how many hours of sleep do you get a night?

☐ 0-3 ☐ 4-6 ☐ 7-10 ☐ 10+

28. Compared to a year ago, how would you rate your health now?

☐ Better ☐ Same ☐ Worse ☐ Unsure

29. Are you satisfied with your Primary Care Doctor/Provider?

☐ Yes ☐ No ☐ I don't know my who my provider is

Any other comments about your 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 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 you decline case management and a follow-up call in six months from ATRIO (per Centers of Medicare and Medicaid Services, D-SNP regulation).

I opt out of case management: ☐ Yes ☐ No

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.