HEALTH RISK ASSESSMENT

Name_____ Date _____

PHYSICAL ACTIVITY

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

___ days

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

___ minutes per day

___ Does not apply

How intense was your typical exercise?

___ Light (like stretching or slow walking)
___ Moderate (like brisk walking)
___ Heavy (like jogging or swimming)
___ Very heavy (like fast running or stair climbing)
___ I am currently not exercising

TOBACCO USE

In the last 30 days, have you used tobacco?

Smoked: ___ Yes
___ No

Used a smokeless tobacco product:

___ Yes
___ No

Would you be interested in quitting tobacco use within the next month?

___ Yes
___ No

ALCOHOL USE

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

___ days

On days when you drank alcohol, how often did you have 4-5 alcoholic drinks on one occasion?

___ Never
___ Once during the week
___ 2-3 times during the week
___ More than 3 times during the week

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

___ Yes
___ No

NUTRITION

In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1 cup fresh vegetables, ½ cup cooked vegetables, 1 medium piece of fruit. 1 cup is size of a baseball)

___ servings per day

In the past 7 days, how many servings of high fiber or whole grain foods did you typically eat each day? (1 serving = 1 slice whole wheat bread, 1 cup whole grain /high fiber ready to eat cereal, ½ cup cooked cereal, ½ c cooked brown rice or wheat pasta)

___ servings per day

In the past 7 days, how many servings of fried or high fat foods did you typically eat each day? (Examples: fried chicken, fried fish, bacon, French fries, potato chips, doughnuts, creamy salad dressings and foods made with whole milk, cream, cheese or mayonnaise)

___ servings per day

In the past 7 days, how many *sugar sweetened* (not diet) beverages did you typically consume each day?

___ sugar sweetened beverages consumed per day

SEAT BELT USE

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

___ Yes
___ No

DEPRESSION

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

___ Almost all of the time
___ Most of the time
___ Some of the time
___ Almost never

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

___ Almost all of the time
___ Most of the time
___ Some of the time
___ Almost never

Have your feelings caused you distress or interfered with your ability to get along socially with family or friends?

___Yes
___ No

ANXIETY

In the past 2 weeks, how often have you felt nervous, anxious or on edge?

___ Almost all of the time
___ Most of the time
___ Some of the time
___ Almost never

In the past 2 weeks, how often were you not able to stop worrying or control your worrying?

___ Almost all of the time
___ Most of the time
___ Some of the time
___ Almost never

HIGH STRESS

How often is stress a problem for you in handling such things as:

___ Your health
___ Your finances
___ Your family or social relationships
___ Your work
    ___ Never or rarely
    ___ Sometimes
    ___ Often
    ___Always

SOCIAL/EMOTIONAL SUPPORT

How often do you get the social and emotional support you need

___ Always
___ Usually
___ Sometimes
___ Rarely
___ Never

PAIN

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

___ None
___ Some
___ Alot

GENERAL HEALTH

In general, would you say your health is

___ Excellent
___ Very good
___ Good
___ Fair
___ Poor

How would you describe the condition of your mouth and teeth – including false teeth or dentures

___ Excellent
___ Very good
___ Good
___ Fair
___ Poor

ACTIVITIES OF DAILY LIVING

In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing or using the toilet?

___ Yes
___ No

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

In the past 7 days, did you need help from others to take care of the things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation or taking your own medications?

___ Yes
___ No

SLEEP

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

___ hours

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

___ Yes
___ No

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

___ Always
___ Usually
___Sometimes
___ Rarely
___ Never

LIST ADDITIONAL PROVIDERS

Doctor's Name	Specialty	Phone #