Crystal Run Healthcare
155 Crystal Run Road
Middletown, NY 10941
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## Health Risk Assessment Form

Patient Name______________________________________ Date_______________

Date of Birth______________________ Male/Female_________________

### Health Risk Assessment Form (HRA) 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

If Yes to either,

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 ___ (5 or more for men, 4 or more for women) and those men and women 65 years old or over)) 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 of fresh vegetables, ½ cup of cooked vegetables, or 1 medium piece of fruit. 1 cup = 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 of 100% whole wheat bread, 1 cup of whole-grain or high-fiber ready-to-eat cereal, ½ cup of cooked cereal such as oatmeal, or ½ cup of cooked brown rice or whole wheat pasta.)

_______ Servings per day

(Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn 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 ☐ A lot

**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, walking, 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 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

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**<u>Biometric Measures—Self-Reported</u>**

(To be completed by the patient only when the HRA is not prepopulated using laboratory, electronic medical record (EMR), patient health record (PHR), or other medical practice source data.)

**Blood Pressure**

If your blood pressure was checked *within the past year*, what was it when it was last checked?

☐ Low or normal (at or below 120/80) ☐ Borderline high (120/80 to 139/89) ☐ High (140/90 or higher)
☐ Don't know/not sure

**Cholesterol**

If your cholesterol was checked *within the past year*, what was your total cholesterol when it was last checked?

☐ Desirable (below 200) ☐ Borderline high (200–239) ☐ High (240 or higher) ☐ Don't know/not sure

**Blood Glucose**

If your glucose was checked, what was your fasting blood glucose (blood sugar) level the last time it was checked?

☐ Desirable (below 100) ☐ Borderline high (100–125) ☐ High (126 or higher) ☐ Don't know/not sure

If diabetic, and if you have had your hemoglobin A1c level checked in the past year, what was it the last time you had it checked?

☐ Desirable (6 or lower) ☐ Borderline high (7) ☐ High (8 or higher) ☐ Don't know/not sure

**Overweight/Obesity**

What is your height without shoes? (For example, 5 feet and 6 inches = 5'6") Feet ___ Inches ______

What is your weight? Weight in pounds ______

Patient signature___________________________________________ Date_____________________