Health Risk Assessment (HRA)

Member Name

Address

City State Zip

Phone Number

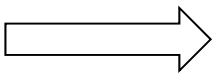
State ID Number:

Thank you for choosing the Integrated Community Health Partners (ICHP) as your health plan.

We would like to ask you some questions to help us understand your healthcare needs and to better serve you. Your answers are confidential and will not change your current coverage. Please complete this questionnaire. After you finish it, please mail it back to us in the postage paid envelope that we have provided (you do not need to put a stamp on it).

You can also call us and give your answers to a care manager. Please call toll free (855) 959-7340.

Please turn this page to view your questionnaire.



Do you have general questions for us?
Do you need help reading this document or need it in another language?
Please call ICHP Customer Service at (855) 959-7340

Este documento puede estar disponible en un formato diferente o idioma. Para obtener información adicional, llame al servicio al cliente en el número de teléfono que aparece arriba.

Health Risk Assessment for Teens (11 years through 17)

1	Do you need help, such as an interpreter, to speak and understand English?	☐Yes ☐No
2	Do you have any spiritual or cultural beliefs that need to be a part of your healthcare?	☐Yes ☐No
3	Are you deaf, or do you have serious difficulty hearing?	☐Yes ☐No
4	Are you blind, or do you have serious difficulty seeing, even when wearing glasses?	☐Yes ☐No
5	Would you currently say that your health and quality of life is worse than it was 1 year ago?	☐Yes ☐No
6	Would you currently say that your mental health is worse than it was 1 year ago?	☐Yes ☐No
7	Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	☐Yes ☐No
8	Do you feel you are getting enough sleep?	☐Yes ☐No
9	If you need help, are you getting the help you need with self-care activities such as bathing, dressing, eating, and going to the bathroom?	☐Yes ☐No ☐N/A
10	If you need help, are you getting the help you need with moving around -- like getting in and out of bed, walking, meal preparation, or eating?	☐Yes ☐No ☐N/A
11	In the past 6 months, have you fallen or had problems with balance or walking?	☐Yes ☐No
12	Has your doctor ever told you that you have any of the following diseases: Asthma? Diabetes or high blood sugar?	☐Yes ☐No
13	Has your doctor ever told you that you are overweight or obese?	☐Yes ☐No
14	Are you suffering from chronic, physical pain?	☐Yes ☐No
15	If you have prescriptions, do you take them as your doctor has told you to?	☐Yes ☐No
16	Overall, are you getting the care you need?	☐Yes ☐No
17	Have you felt down, depressed, or hopeless on most of the days in the past 2 weeks?	☐Yes ☐No
18	In the last thirty days, have you talked about your problems, feelings, or opinions with someone in your family?	☐Yes ☐No
19	In the last thirty days, was someone there for you when you needed someone to listen or to help you?	☐Yes ☐No
20	Because of a physical, mental, or emotional condition, have you missed time at school, at work, or with your friends?	☐Yes ☐No
21	In the last thirty days, did you smoke or chew tobacco, have unprotected sex, or drink alcohol including beer and wine?	☐Yes ☐No
22	In the last thirty days, did you use illegal drugs including marijuana or prescription drugs for non-medical purposes?	☐Yes ☐No
23	Do you use a seatbelt? Do you wear a helmet with riding a bicycle, skateboard, etc.?	☐Yes ☐No
24	Do you have any concerns about violence or abuse, sexual issues or birth control, sexually transmitted diseases and AIDS, depression and suicide, exercise, nutrition and eating disorders?	☐Yes ☐No
25	In the last thirty days, have you had times when there wasn't enough to eat at home?	☐Yes ☐No
26	In the last year, have you seen a dentist, eye doctor, counselor, or other doctor?	☐Yes ☐No
27	Do you have a reliable way to get to school? To work? To appointments?	☐Yes ☐No
28	In the event you become unable to make medical decisions for yourself, do you have a power of attorney, living will or advance directive?	☐Yes ☐No