Integritas Wellness Institute - Medicare Health Risk Assessment

This is a TWO pages questionnaire. Please answer to the best of your abilities.

Name _____ Date of Birth_____/_____/_____

Today's Date _____/_____/_20_____

1. Gender □ Man □ Woman

2. Race (please check all that apply) □ White □ Black/African American

□ Asian or Pacific Islander □ American Indian □ Hispanic or Latino □ Other _____

3. In the past 2 weeks, did you feel down, depressed, anxious, irritable or hopeless?

□ Yes □ No

4. In the past 2 weeks, did you felt little interest or pleasure in doing things?

□ Yes □ No

5. In the past 4 weeks, did you have to limit your social activities with your family & friends due to your physical or emotional health? □ Yes □ No

6. In the past 4 weeks, how much pain in your body have you had?

□ None □ Moderate □ Mild □ Severe

7. In the past 4 weeks, how often did fatigue bother you?

□ Not at all □ Sometimes □ Frequently □ Always

8. Are you able to get to places out of walking distance without help?

(For example, can you travel alone on buses or taxis, or drive your own car?) □ Yes □ No

9. Are you able to go shopping for groceries or clothes without someone's help? □ Yes □ No

10. Are you able to do your housework without help? □ Yes □ No

11. Are you capable of handling your own money (finances) without help? □ Yes □ No

12. Are you able to prepare your own meals? □ Yes □ No

13. Are you able to manage your own medications without help? □ Yes □ No

14. Do you typically exercise for at least 20 minutes three or more days per week?

□ Yes □ No □ Some of the time

15. Do you typically fasten your seatbelt when you are in a car? □ Yes □ No

16. In the past 4 weeks, did you have someone available for you to help you if you needed and wanted help? (For example, if you felt nervous or sad, got sick, needed someone to talk to, or needed help taking care of yourself)

□ Yes, as much as I needed □ Yes, somewhat □ No, not at all

Medicare Health Risk Assessment

17. Because of any health problems, do you need the help of another person with your personal care needs, such as eating, bathing, dressing or getting around the house? □ Yes □ No

18. Did you suffer two or more times from falls in the past year? □ Yes □ No

19. Do you have a fear of falling? □ Yes □ No

20. Do you smoke? □ Yes □ No

21. In the past 4 weeks, how many alcoholic beverages did you consume?

□ None □ 1-5 drinks per week □ 6-9 drinks per week □ 10 or more drinks per week

22. Do you have any difficulties operating your vehicle? □ Yes □ No □ I do not drive

23. Do you suffer from any difficulties with your hearing (auditory problems)? □ Yes □ No

24. Do you have any difficulties with operating the telephone? □ Yes □ No

25. Do you have any worries of your sexual health? □ Yes □ No

26. Do you have any problems with eating well? □ Yes □ No

27. Do you have any dental or denture problems (teeth concerns)? □ Yes □ No

28. Would you say that are there are hazards in your home that may put you at risk? (For example, rugs in the hallways, missing stairs handrails, low lighting, electrical cords in walking areas)

□ Yes □ No □ Not sure

29. How confident are you that you can control and manage your own health?

□ Very confident □ Somewhat confident □ Not very confident

30. If you were to rate your overall health, what would you rate it at?

□ Excellent □ Very good □ Good □ Fair □ Poor

END OF QUESTIONNAIRE – THANK YOU