ROBERT M. KERPER, PLLC

HEALTH RISK ASSESSMENT

NAME: _____
Date of Birth: _____

HOME AND SAFETY

What is your home living arrangement (house, apartment, independent living, etc)?
_____
Do you have safety concerns about your home arrangement? _____
Who lives with you?_____
Who are your closest supports? _____
What other medical professionals do you see for specialty care? _____
_____
In the past 7 days, how much pain have you felt? None Some A lot

FUNCTION AND INDEPENDENCE

Do you have significant difficulties with hearing? Yes No

Do you have significant difficulties with vision? Yes No

Are you currently receiving services such as physical therapy, occupational therapy, home health aide, etc? Yes No
If so, please explain _____

Do you use any equipment to help with mobility such as a rolling walker, wheelchair, etc.? Yes No *If so, what kind?* _____

Do you have difficulties with bladder control? Yes No
If so, how do you manage it? _____

Have you had any falls in the last year? Yes No
If so, how many and how did they happen? _____

_____

Do you always fasten your seatbelt when you are in a car? Yes No

Do you have a problem with balance? Yes No

ACTIVITIES of DAILY LIVING SCALE

Yes No In the past 7 days, did you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, getting in or out of a bed or chair, or using the toilet?
If yes, please circle the everyday activities you needed help with:

Eating	Getting dressed
Bathing	Walking
Using the toilet	Getting in and out of a chair
Getting in and out of bed	

Yes No Do you usually need help from others to take care of things such as laundry and housekeeping, shopping, banking, using the telephone, food preparation, transportation, or taking your medications?
If so, please explain: _____
_____

HEALTH HABITS AND NUTRITION

Yes No Do you eat a healthy balanced diet with minimal salt and "bad fats"?

Yes No Have you had any unintentional weight loss in the past 6 months?
If yes, please indicate the amount of your weight loss: ___ *lbs.*

Yes No Do you use recreational drugs including marijuana?
If yes, what kind and how often? _____

Yes No Do you take all your prescription medications as prescribed?
*If not, why (side effects, cost, trouble remembering, etc.)?*_____

How many drinks of alcohol on average do you have per week? _____

How often did you have 4 or more drinks on one occasion? _____

What is your history of smoking cigarettes?
Current Smoker Former Smoker Never Smoked

If you are a current or former smoker, how many pack years did you smoke? (Multiply packs per day X number of years smoked. For example: 2 packs per day X 20 years smoked = 40 pack years) _____

If you are a former smoker, when did you stop smoking cigarettes?

More than 15 years ago Less than 15 years ago

If you are a current smoker, have you attended a Smoking and Tobacco Use Cessation Counseling session within the last 12 months? Yes No

DEPRESSION SCREEN

Over the last two weeks, how often have you been bothered or had little interest or pleasure in doing things?

____not at all
____several days
____more than half the days
____nearly everyday

Over the last two weeks, how often have you been bothered by feeling down or depressed?

____not at all
____several days
____more than half the days
____nearly everyday

ADVANCE DIRECTIVES

Have you completed a Health Care Proxy or another advance directive such as a Living Will or MOLST form? ____*Yes* ____*No*
If not, would you like to discuss this? ____*Yes* ____*No*

SELF-ASSESSMENT

Considering your age, how would you describe your overall health?

____Excellent ____Very Good ____Good ____Fair ____Poor

How much difficulty, if any, do you have walking a 1/4 mile which is about 2 or 3 blocks?

____No difficulty at all ____A little difficulty ____Some difficulty

____A lot of difficulty ____Not able to do it