Mountain Valleys
HEALTH CENTERS

Medicare Annual Wellness Visit Health Risk Assessment

Patient Name **D.O.B.**

Self Assessment of Health Status

What is your race?	☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black ☐ Native Hawaiian ☐ Pacific Islander ☐ Unknown ☐ White
Over the last 4 weeks, how would you rate your health?	☐ Excellent ☐ Good ☐ Fair ☐ Poor
Do you eat 5 servings of fruits & vegetables a day?	☐ Yes ☐ No
Do you exercise at least 20 minutes, 3 or more times per week?	☐ Yes ☐ No
Are you or a family member concerned about your memory?	☐ Yes ☐ No
Do you feel overly tired or fatigued often?	☐ Yes ☐ No
Do you have any physical pain that limits your activities?	☐ Yes ☐ No

Psychosocial Risks

In the past 4 weeks, have you felt lonely?	☐ Yes ☐ No ☐ Some of the time
In the past 4 weeks, have you felt angry?	☐ Yes ☐ No ☐ Some of the time
In the past 4 weeks, have you felt isolated?	☐ Yes ☐ No ☐ Some of the time
In the past 4 weeks, have you felt stressed?	☐ Yes ☐ No ☐ Some of the time
In the past 4 weeks, have you had sexual difficulty?	☐ Yes ☐ No ☐ Some of the time

PHQ-2 - Behavioral Risks (Past 2 Weeks)

Little interest or pleasure in doing things	☐ 0-Not at all ☐ 1-Several Days ☐ 2-More than half the days ☐ 3-Nearly every day
Feeling down, depressed, or hopeless	☐ 0-Not at all ☐ 1-Several Days ☐ 2-More than half the days ☐ 3-Nearly every day
Total Score=	

***This additional PHQ-9 screening should only be provided to the patient to complete or be conducted through patient interview by a clinical staff member, IF the PHQ-2 was positive.**

Home Safety

Question	Response
Do you have trouble hearing? If yes, do you have a hearing aid?	☐ Yes ☐ No ☐ Yes ☐ No
Does your home have rugs in the hallway?	☐ Yes ☐ No
Do you have grab bars in the bathroom?	☐ Yes ☐ No
Have you fallen in the past 12 months? If yes, how many times?	☐ Yes ☐ No _________ Number of times fallen
Does your home have poor lighting?	☐ Yes ☐ No
Do you have handrails on the stairs?	☐ Yes ☐ No

Activities of Daily Living (Past 4 Weeks have you had...)	Yes/No	If Yes...
Difficulty walking across a room (including using a cane or a walker?)	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty going up or down the stairs?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty standing up or sitting down?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty dressing?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty brushing teeth?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty bathing or taking a shower?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty using the toilet?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?

Activities of Daily Living (Past 4 Weeks have you had...)	Yes/No	If Yes...
Difficulty feeding yourself?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty managing medications?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty cooking?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty housecleaning?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty doing laundry?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty using a computer	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty using the phone?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty managing finances or paying bills?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty using public transportation?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?
Difficulty shopping?	☐ Yes ☐ No	☐ Do you need help with this task? ☐ Do you have help with this task? ☐ Is your family concerned about you performing this task?

Advanced Directive

Do you have a Healthcare Directive completed on file in your electronic health record?	☐ Yes ☐ No
Do you want help updating or completing a Healthcare Directive?	☐ Yes ☐ No

Clinical Staff Only

***This additional PHQ-9 screening should only be provided to the patient to complete or be conducted through patient interview by a clinical staff member, IF the PHQ-2 was positive.**

PHQ-9 - Over the last 2 weeks, how often have you been bothered by any of the following problems?
0=Not at all 1=Several Days 2=More than half the days 3=Nearly every day

Trouble falling or staying asleep or sleeping too much	______
Feeling tired or having little energy	______
Poor appetite or overeating	______
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	______
Trouble concentrating on things like schoolwork, reading, or watching TV	______
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	______
Thought you would be better off dead or of hurting yourself in some way	______
Total Score =	______

PHQ-9 - Disability and Additional Questions

If you checked off any problems, how difficult have these problems been?	☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult