

ICW HEALTH RISK ASSESSMENT

HEALTH RISK ASSESSMENT (HRA)

ID: _____

Clinician Name: _____ Date Completed: _____

_____ Baseline _____ 6 Months _____ 12 Months

Please complete the following questions to the best of your ability.

Instrumental Activities of Daily Living Scale (I.A.D.L.)

For each category, circle the item description that most closely resembles your highest functional level. If you circle a 0, please indicate whether or not they have someone available to them to support them with these tasks.

A. Shopping

- | | |
|---|---|
| 1. Takes care of all shopping needs independently | 1 |
| 2. Shops independently for small purchases | 0 |
| 3. Needs to be accompanied on any shopping trip | 0 |
| 4. Completely unable to shop | 0 |

If no (0 Points), do you have someone to support you with this task? Yes No

B. Housekeeping

- | | |
|---|---|
| 1. Maintains house alone or with occasional assistance (e.g., "heavy work domestic help") | 1 |
| 2. Performs light daily tasks such as dish washing, bed making | 1 |
| 3. Perform light daily tasks but cannot maintain acceptable level of cleanliness | 1 |
| 4. Needs help with all home maintenance tasks | 1 |
| 5. Does not participate in any housekeeping tasks | 0 |

If no (0 Points), do you have someone to support you with this task? Yes No

C. Ability to Handle Finances

- | | |
|---|---|
| 1. Manages financial matters independently (budgets, writes checks, pays rent, bills, goes to the bank), collects and keeps track of income | 1 |
| 2. Manages day-to-day purchases, but needs help with banking, major purchases, etc. | 1 |
| 3. Incapable of handling money | 0 |

If no (0 Points), do you have someone to support you with this task? Yes No

D. Responsibility for Own Medications

- | | |
|---|---|
| 1. Is responsible for taking medication in correct dosages at correct time | 1 |
| 2. Takes responsibility if medication is prepared in advance in separate dosage | 0 |
| 3. Is not capable of dispensing own medication | 0 |

If no (0 Points), do you have someone to support you with this task? Yes No

ACTIVITIES OF DAILY LIVING (A.D.L.)

For each activity, indicate your level of dependence by marking the appropriate box.

<p>Activities Points (1 or 0)</p>	<p>Independence (1 point) NO supervision, direction, or personal assistance.</p>	<p>Dependence (0 points) WITH supervision, direction, or personal assistance.</p>
<p>Bathing</p>	<p>Bathes self completely or needs help in bathing only a single part of the body, such as the back, genital area, or disabled extremity. <i>If no (0 points), do you have someone to support you with this task?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Needs help bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.</p>
<p>Dressing</p>	<p>Get clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes. <i>If no (0 points), do you have someone to support you with this task?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Needs help with dressing self or needs to be completely dressed.</p>

SELF-RATED HEALTH

In general, how good would you say your health is?

- Excellent 1
- Very Good 2
- Good 3
- Fair 4
- Poor 5

ORAL HEALTH

Do you have tooth or mouth problems that make it difficult or painful for you to eat? Yes No

SARC-F SCREEN FOR SARCOPENIA

How much difficulty do you have walking across a room?

- None 0
- Some 1
- A lot or unable 2

How many times have you fallen in the last year?

- None 0
- One to three falls 1
- Four or more falls 2

SIMPLE FRAIL QUESTIONNAIRE

Are you fatigued?	No 0	Yes 1
Cannot walk up one flight of stairs?	No 0	Yes 1
Cannot walk one block?	No 0	Yes 1
Do you have more than five illnesses?	No 0	Yes 1
Have you lost more than 5% of your weight in the last six months?	No 0	Yes 1

PAIN

During the PAST FOUR WEEKS, how much bodily pain have you generally had?

No pain	1
Very mild pain	2
Mild pain	3
Moderate pain	4
Severe pain	5

HEARING

During the PAST FOUR WEEKS, how often have you had trouble hearing?

Never	1
Seldom	2
Sometimes	3
Often	4
Always	5

MEMORY

During the PAST FOUR WEEKS, how often have you had trouble thinking or remembering?

Never	1
Seldom	2
Sometimes	3
Often	4
Always	5

SEXUAL PROBLEMS

During the PAST FOUR WEEKS, how often have you had sexual problems?

Never	1
Seldom	2
Sometimes	3
Often	4
Always	5

SIMPLIFIED NUTRITIONAL ASSESSMENT QUESTIONNAIRE (SNAQ)

My appetite is:

- Very Poor 1
- Poor 2
- Average 3
- Good 4
- Very Good 5

When I eat:

- I feel full after eating only a few mouthfuls 1
- I feel full after eating about a third of a meal 2
- I feel full after eating over half of a meal 3
- I feel full after eating most of a meal 4
- I hardly ever feel full 5

Food tastes:

- Very Bad 1
- Bad 2
- Average 3
- Good 4
- Very Good 5

Normally I eat:

- Less than one meal per day 1
- One meal per day 2
- Two meals per day 3
- Three meals per day 4
- More than three meals per day 5

UCLA LONELINESS SCALE

How often do you feel that you lack companionship?	1=Never	2=Rarely	3=Sometimes	4=Always
How often do you feel left out?	1=Never	2=Rarely	3=Sometimes	4=Always
How often do you feel isolated from others?	1=Never	2=Rarely	3=Sometimes	4=Always

SUBJECTIVE HAPPINESS SCALE

For each of the following statements or questions, please circle the point on the scale that you feel is most appropriate in describing you.

In general, I consider myself:

1	2	3	4	5	6	7
Not a very happy person						A very happy person

Compared with most of my peers, I consider myself:

1	2	3	4	5	6	7
Less happy						More happy

Some people are generally very happy. They enjoy life regardless of what is going on, getting the most out of everything. To what extent does this characterization describe you?

1	2	3	4	5	6	7
Not at all						A great deal

Some people are generally not very happy. Although they are not depressed, they never seem as happy as they might be. To what extent does this characterization describe you?

1	2	3	4	5	6	7
Not at all						A great deal

DEPRESSION (PHQ2/9)

Over the last two weeks, how often have you been bothered by any of the following problems?

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

PERCEIVED STRESS SCALE (PSS-4)

In the last month, how often have you felt that you were unable to control the important things in your life?

Never Almost never Sometimes Fairly often Very often

In the last month, how often have you felt confident about your ability to handle your personal problems?

Never Almost never Sometimes Fairly often Very often

In the last month, how often have you felt that things were going your way?

Never Almost never Sometimes Fairly often Very often

In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

Never Almost never Sometimes Fairly often Very often

SATISFACTION WITH LIFE

For each of the following statements or questions, please select the answer that you feel is most appropriate in describing you.

In most ways, my life is close to ideal

- | | | | | | | |
|-------------------|----------|-------------------|----------------------------|----------------|-------|----------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Strongly Disagree | Disagree | Slightly Disagree | Neither Agree nor Disagree | Slightly Agree | Agree | Strongly Agree |

The conditions of my life are excellent

- | | | | | | | |
|-------------------|----------|-------------------|----------------------------|----------------|-------|----------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Strongly Disagree | Disagree | Slightly Disagree | Neither Agree nor Disagree | Slightly Agree | Agree | Strongly Agree |

I am satisfied with my life

- | | | | | | | |
|-------------------|----------|-------------------|----------------------------|----------------|-------|----------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Strongly Disagree | Disagree | Slightly Disagree | Neither Agree nor Disagree | Slightly Agree | Agree | Strongly Agree |

So far, I have gotten the important things I want in life

- | | | | | | | |
|-------------------|----------|-------------------|----------------------------|----------------|-------|----------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Strongly Disagree | Disagree | Slightly Disagree | Neither Agree nor Disagree | Slightly Agree | Agree | Strongly Agree |

If I could live my life over, I would change almost nothing

- | | | | | | | |
|-------------------|----------|-------------------|----------------------------|----------------|-------|----------------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Strongly Disagree | Disagree | Slightly Disagree | Neither Agree nor Disagree | Slightly Agree | Agree | Strongly Agree |

SMOKING

Do you currently smoke? Yes No

If no:

Have you ever smoked in the past? Yes No

Year quit: _____

EXERCISE

On how many of the last seven days did you participate in at least 30 minutes of physical activity?

- | | | | | | | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|

ALCOHOL USE (AUDIT-C)

How often do you have a drink containing alcohol?

Never	0
Monthly or less often	1
2 to 4 times a month	2
2 to 3 times a week	3
4 or more times a week	4

Total score: _____ /4

Scoring: If total score is more than one, continue asking the following questions:

How many standard drinks containing alcohol do you have on a typical day when you are drinking?

1 to 2	0
3 to 4	1
5 or 6	2
7 to 9	3
10 or more	4

How often do you have 6 or more drinks on one occasion?

Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4

TRANSPORTATION

Do you drive? Yes No

If yes, do you or someone close to you, feel that driving a car is difficult for you? Yes No

Do you feel safe while driving? Yes No

Do you have access to a car that you can use to get around with? Yes No

How often do you use a seat belt when you drive or ride a car?

Never drive or ride	0
Always	1
Nearly always	2
Sometimes	3
Seldom	4
Never uses a seatbelt	5

I need access to general transportation to do grocery shopping, going to social events, etc. Yes No

If yes, to what extent were you able to get access to general transportation when you needed it?

- | | |
|---------------|---|
| Always | 1 |
| Nearly always | 2 |
| Sometimes | 3 |
| Seldom | 4 |
| Never | 5 |

I need access to non-emergency medical transportation to go to a doctor, pick up medications, going for specialized medical services, etc. Yes No

If yes, to what extent were you able to get access to non-emergency medical transportation when you needed it?

- | | |
|---------------|---|
| Never | 1 |
| Almost never | 2 |
| Sometimes | 3 |
| Almost always | 4 |
| Always | 5 |

HOME SAFETY

As I move from room to room in my house, I slip or stumble from clutter, electrical cords, low furniture, or other things in my path

- | | |
|-----------------------|---|
| Never | 1 |
| Rarely | 2 |
| Once a week | 3 |
| More than once a week | 4 |

Do you have a medical alert system that helps you alert help if you should fall, having trouble breathing, need an ambulance, or get locked out of the house? Yes No

Do you have a smoke detector and a carbon monoxide detector?

- | | |
|--|---|
| Yes, both smoke and carbon monoxide detector | 1 |
| Only a smoke detector | 2 |
| Only a carbon monoxide detector | 3 |
| No to both | 4 |
| Don't know | 5 |