CENTRAL ARIZONA MEDICAL ASSOCIATES, P.C.

Name ________________________________ Date of Birth___________ Today's Date___________

Health Risk Assessment

1. In general, how would you describe your health?
   [ ] Excellent [ ] Very good [ ] Good [ ] Fair [ ] Poor

2. How would you describe the condition of your mouth and teeth (including dentures)?
   [ ] Excellent [ ] Very good [ ] Good [ ] Fair [ ] Poor

3. On how many days per week do you eat a variety of fruits, vegetables, and whole grains? ______ days

4. On how many days per week do you drink sugar-sweetened beverages? ______ days

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Psychological

1. How often do you get the social and emotional support you need:
   [ ] Always [ ] Usually [ ] Sometimes [ ] Rarely [ ] Never

2. How much chronic pain are you experiencing on a 0 - 10 scale?
   [ ] 0 [ ] 2 [ ] 4 [ ] 6 [ ] 8 [ ] 10

PHQ-9

Over the last two weeks, how often have you been bothered by the following:

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
Thoughts that you would be better off dead or thoughts of hurting yourself in some way	0	1	2	3
Total each column				

How difficult have these problems made it for you to do your work, take care of things at home, or get along with others?
[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult

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Behavioral

1. In the past 7 days, how many days did you exercise? ______ days _______ minutes per day

2. In the last 30 days, have you used tobacco?
   Cigarettes? [ ] Yes [ ] No Smokeless tobacco? [ ] Yes [ ] No

3. How often do you have a drink containing alcohol?
   [ ] Never [ ] Monthly or less [ ] 2-4 times a month [ ] 2-3 times a week [ ] 4 or more times a week

4. How many standard drinks containing alcohol do you have on a typical day?
   [ ] 1 or 2 [ ] 3 or 4 [ ] 5 or 6 [ ] 7 to 9 [ ] 10 or more

5. How often do you have 6 or more drinks on one occasion?
   [ ] Never [ ] Less than monthly [ ] Monthly [ ] Weekly [ ] Daily or almost daily

6. Do you always fasten your seatbelt in the car? [ ] Yes [ ] No

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Activities of Daily Living:
In the past 7 days, did you need help from others for eating, getting dressed, grooming, bathing, walking, or using the toilet?
[ ] Yes [ ] No

Instrumental Activities of Daily Living:
In the past 7 days, did you need help for shopping, housekeeping, managing medications, handling finances?
[ ] Yes [ ] No

Hearing Screening

<-------*Please check one*--------->

QUESTIONS	YES (4pts)	SOMETIMES (2pts)	NO (0pts)
Does a hearing problem cause you to feel embarrassed when you meet new people?			
Does a hearing problem cause you to feel frustrated when talking to members of your family?			
Do you have difficulty hearing when someone speaks in a whisper?			
Do you feel handicapped by a hearing problem?			
Does a hearing problem cause you to attend religious services less often that you would like?			
Does a hearing problem cause you to have arguments with family members?			
Does a hearing problem cause you difficulty when listening to TV or radio?			
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			
TOTAL POINTS			

For Office Use Only
Score Interpretation:
- ☐ 0 – 8 suggests no hearing handicap
- ☐ 10 – 24 suggests mild-moderate hearing handicap
- ☐ 26 – 40 suggests significant hearing handicap

Current Provider List

Please list the names of all the doctors that you see regularly and yearly

(Use the backside of this page if you need more space to write)

Name of Doctor	Specialty

Current Medication List

Please list all of the medicines you take including over-the-counter drugs and vitamins

(Use the backside of this page if you need more space to write)

Name of Medicine	Dose

Current Medical Equipment Suppliers

Please list the company and the equipment supplied:

Company	Medical Equipment

HRA reviewed by: ______________________________

Provider Signature

Tami Bruce, MD **Robert Laufer, DO** **Trevor Whiting, PA-C** **Lori Schroder, FNP-C** **Lindsay Farwick, FNP-C**