Adult Health Risk Assessment Questionnaire

Date: ________________

Patient Name: _______________________________ Date of Birth__________________

In general would you say your health is ◯ Excellent ◯ Very Good ◯Good ◯ Fair ◯ Poor

Pain Assessment

How often have you had pain during the past 3 months?

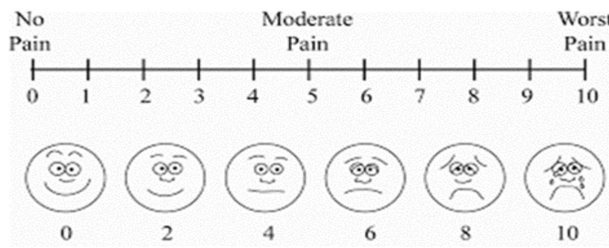
◯ not at all ◯ some days ◯ most days ◯ every day

How often during the past 3 months has pain kept you from doing activities you enjoy?

◯ not at all ◯ some days ◯ most days ◯ every day

****please mark with an X current pain level if applicable in the pain scale shown below****

0-10 Numeric Pain Rating Scale



Exercise Frequency

How intense is your typical exercise? (Check one) ___I am currently not exercising ___ Light (like stretching or slow walking) ___Moderate (like brisk walking) ___Heavy (like jogging or swimming) ___Very heavy (like fast running or stair climbing)

PATIENT SIGNATURE______________________ PROVIDER SIGNATURE_______________________

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Sep 2019

Depression Screening-PHQ9

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 everyday

***Little interest or pleasure in doing things you once enjoyed_____**
***Feeling down, depressed or hopeless ____**
***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, such as reading the newspaper or watching television______**
***Moving or speaking so slowly that other people could have noticed, or the opposite- being so fidgety or restless, and you are moving around more than usual______**
***Thoughts that you would be better off dead, or thoughts of hurting yourself in some way_____** **PHQ-9 SCORE /27**

Alcohol Assessment

Do you consume alcohol? □ Yes □ No

If yes, please answer the following questions below. Thank you!

C.A.G.E

C - Have you ever felt you should *cut down* on your drinking? □ Yes □ No
A - Have people *annoyed* you by criticizing your drinking? □ Yes □ No
G- Have you ever felt bad or *guilty* about your drinking? □ Yes □ No
E- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? (*Eye opener)* □ Yes □ No

Habit Assessment

Tobacco(chew, cigar,pipe,cigarette)	Do you use tobacco products now or in the past? □ Yes □ No Number of years:_______ Number of packs per day:_________ □ Former Smoker Quit Date_______
Nicotine (vape)	□ Never □ Current □ Former
Recreational Drugs	□ Never □ Current □ Social/Occasional What drug(s)? ____________________________ □ Former User What drug(s)? ________________________________

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