



ACA Health Risk Assessment Questionnaire

Enrollee Information							
Name:				Date of Birth (MM/DD/YYYY):			
Gender:	☐ Female	☐ Male	☐ Prefer not to answer				
Preferred Language:	☐ English		☐ Spanish	☐ Other			
Ethnicity: ☐ White or Caucasian ☐ Black or African American ☐ Pacific Islander/Native Hawaiian ☐ Native American/Alaskan Native ☐ Asian ☐ Other ☐ Unknown ☐ Hispanic/Latino ☐ I prefer not to answer							
Preferred Method of Contact:				☐ Phone		☐ MyChart	
How would you rate your overall health:		☐ Excellent	☐ Good	☐ Fair	☐ Poor		
How much do you need help with the following:							
Bathing	☐ No help	☐ Some help	☐ Can't do at all				
Eating	☐ No help	☐ Some help	☐ Can't do at all				
Preparing meals	☐ No help	☐ Some help	☐ Can't do at all				
Using the bathroom	☐ No help	☐ Some help	☐ Can't do at all				
Dressing	☐ No help	☐ Some help	☐ Can't do at all				
Getting out of bed or chair	☐ No help	☐ Some help	☐ Can't do at all				
Taking medications	☐ No help	☐ Some help	☐ Can't do at all				
Walking	☐ No help	☐ Some help	☐ Can't do at all				
If you need help with any of the above, do you have someone close by or a caregiver who helps you? ☐ Family ☐ Friend ☐ Neighbor ☐ Caregiver ☐ No Help Needed ☐ No Support ☐ Other							
Do you need help finding a Primary Care Physician:						☐ Yes	☐ No
Do you need help finding a mental health specialist:						☐ Yes	☐ No

What is your housing situation today: ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park) ☐ I have housing today, but I am worried about losing housing in the future. ☐ I have housing					
Within the past 12 months, the food you bought just didn't last and you didn't have money to get more? ☐ Often true ☐ Sometimes true ☐ Never true					
In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or getting things needed for daily living? (check all that apply) ☐ Yes, it has kept me from medical appointments or getting medications. ☐ Yes, it has kept me from non-medical meetings, appointments, work, or getting things that I need. ☐ No					
In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home? ☐ Yes ☐ No ☐ Already shut off					
Do you feel physically and emotionally safe where you currently live? ☐ Yes ☐ No ☐ Prefer not to answer					
Do you have dependable internet? (Your internet works well, and stays connected)				☐ Yes	☐ No
Do you have a smartphone or a computer with a camera and a microphone?				☐ Yes	☐ No
Can you download a mobile application or "app" and change browser or camera settings on a computer or smartphone?				☐ Yes	☐ No
Would you like assistance or resources to learn more about scheduling telemedicine/virtual visits?				☐ Yes	☐ No
Have you ever been diagnosed by a provider with any of the following?					
Shortness of Breath	☐ Yes	☐ No	Cardiovascular Disease/Coronary Artery Disease/Peripheral Vascular Disease	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No	COPD/Lung Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Frequent Falls	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Parkinson's	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No	Dementia/Alzheimer's	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No	Vision Loss	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Hearing Loss	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Organ Transplant (kidney, liver, etc)	☐ Yes	☐ No
Quadriplegic/Paraplegic	☐ Yes	☐ No	Depression	☐ Yes	☐ No
Amputee	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Non-healing wounds	☐ Yes	☐ No

Do you currently use nicotine products? (smoking, vaping, chew, etc)	☐ Yes	☐ No
If yes, would you like more information or resources on quitting?	☐ Yes	☐ No
Do you receive the flu vaccine annually?	☐ Yes	☐ No
Do you have an advanced healthcare directive?	☐ Yes	☐ No
If no, would you like more information on advanced healthcare directives?	☐ Yes	☐ No
In an average week, how many alcoholic drinks do you consume? ☐ 1-7 Drinks ☐ 8-14 Drinks ☐ More than 15 ☐ I do not drink		
Do you take your medications as prescribed? Please mark all that apply. ☐ Always ☐ Sometimes ☐ Never ☐ I do not take any medications		
In the last 6 months, have you ever needed to cut your pills in half to make them last longer?	☐ Yes	☐ No
How many medications are you currently prescribed? ☐ 0 ☐ 1-4 ☐ 5-9 ☐ More than 10		
In the last 12 months, how many times have you been to the emergency room? ☐ 0 ☐ 1 ☐ 2 ☐ More than 3		
In the last 12 months, how many times have you been admitted to the hospital? ☐ 0 ☐ 1 ☐ 2 ☐ More than 3		

If you would like more information about our Care Management programs, please contact us at 1-855-962-7325 Monday through Friday from 8:00 am – 5:00 pm. As a member of Peak Health, you also have 24/7 access to a registered nurse for medical advice at 1-833-545-7484

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