ROCKY MOUNTAIN
URGENT CARE & FAMILY MEDICINE

Patient Name ______________________________

Patient Date of Birth ______________________________

Date of Visit ______________________________

ROCKY MOUNTAIN FAMILY MEDICINE HEALTH RISK ASSESSMENT (HRA)

Do you have any other physicians that treat you outside of this clinic?	☐Yes	☐No
Do you receive medical supplies at home from a company other than a pharmacy?	☐Yes	☐No
Do you currently receive any support from the community, such as meal delivery services, PT/OT/RN at home, homemaker assistance, transportation assistance?	☐Yes	☐No

DO YOU HAVE ANY PROBLEMS AT HOME DOING THE FOLLOWING ACTIVITIES:

Bathing	☐Yes	☐No
Dressing	☐Yes	☐No
Using the bathroom	☐Yes	☐No
Getting up from furniture	☐Yes	☐No
Incontinence	☐Yes	☐No
Feeding yourself	☐Yes	☐No

IN YOUR HOME, DO YOU HAVE A:

Smoke alarm that works	☐Yes	☐No
Home escape plan	☐Yes	☐No
Clear escape route	☐Yes	☐No
Phone kept where it can be used for help	☐Yes	☐No
Handrails on both sides of steps	☐Yes	☐No
Nightlights	☐Yes	☐No
Grab bars in tub and shower	☐Yes	☐No
Throw rugs on floor	☐Yes	☐No

1) Have you fallen in the past 6 months?	☐Yes	☐No
2) During the last 3 months, have you leaked urine (even a small amount?)	☐Yes	☐No
3) Do you exercise or do work that is hard enough to make you breathe heavily and make your heart beat faster at least 20 minutes 5 times a week?	☐Yes	☐No
4) Do you eat 3 to 5 servings of vegetables daily?	☐Yes	☐No
5) Do you eat 2 to 4 servings of fruit daily?	☐Yes	☐No
6) Do you have trouble getting where you need to be?	☐Yes	☐No
7) Do you have trouble getting friends or family to help you?	☐Yes	☐No
8) Do you wear your seatbelt 100% of the time when driving/riding in a car or truck?	☐Yes	☐No

IN THE PREVIOUS 12 MONTHS:

9) Have you stayed overnight as a patient?	☐Yes	☐No
10) Have you had 2 or more visits to an urgent care center?	☐Yes	☐No
11) Have you had 2 or more visits to an emergency room (ER)?	☐Yes	☐No