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| □ | Initial |
| □ | 12 month re-assessment |
| □ | Discharge |

**Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)**

Addendum 1 – Health Risk Assessment (HRA)

*Please note: This assessment must be completed for all individuals once every 12 months.*

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| **18. GENERAL INFORMATION (HRA)** |
| Staff Name: | Individual First and Last Name: | RIN: | DOB: | Gender: |
| Height: | Weight: | Primary Care Doctor’s Name: | Date of Last Physical Exam: |
| **19. MEDICATION(S)** List of current and previous medications below, including over-the-counter medications. *Attach additional pages as needed.* |
| Medication Name | Prescriber | Dosage | Date Started | Date Ended | Medication Issues |
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| **20. HEALTH STATUS CANS Rating – Medical/Physical:\_\_\_\_\_\_** |
| **a. Individual’s self-report on general physical health:** |  **f. Does the individual drink alcohol?** |
| □ Excellent | □ Good  | □ Fair | □ Poor |  If yes, how often and how much?\_\_\_\_ |
| **b. How many snack foods or drinks (e.g., chips, cookies, candy, soda) does the individual usually consume in a day?** | **g. Has the individual ever fainted or passed out?** □ Yes □ No |
| □ 0-1 | □ 2-3  | □ More than 4 | If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **c. How many servings of fruits and vegetables does the individual usually eat in a day?** | **h. How does the individual have any allergies?** □ Yes □ No |
| □ 0-1 | □ 2-3  | □ More than 4 | If yes, list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **d. Does the individual engage in physical activity?** | **i. Has the individual fallen in the past 12 months?** □ Yes □ No |
| □ 0-1 | □ 2-3  | □ More than 4 | If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **e. Does the individual use any form of tobacco?** □ Yes □ No | **j. Does the individual want help to quit smoking?** □ Yes □ No |
| **HEALTH CONCERNS:** **Does the individual have any current health concerns?** □ Yes □ No If yes, describe below: | **GENERAL ILLNESS:****Does the individual have a tendency to any illnesses?** □ Yes □ No If yes, describe: |
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| **BREATHING ISSUES:** **Does the individual have any trouble breathing?** □ Yes □ No (If *NO*, skip to next section) | **CONGNITIVE ASSESSMENT:** *(skip if the individual us under age 50)* |
| a. What are the breathing issues  related to? Check all that apply: | a. Has the individual ever had a significant  head injury? □Yes □No If yes, when? \_\_\_ |
| □ Physical  activity  | □ Weather extremes  | □ Other: \_\_\_\_\_\_\_\_\_\_ | b. Does the individual have any difficulty  remembering or recalling events?  □ Yes □ No |
| b. Does the individual take medication  for breathing issues? □ Yes □ No | c. Can the individual correctly tell you what  year, month, and day it is? □ Yes □ No |
| **BLOOD SUGAR/DIABETES:** | **CHRONIC PAIN: Does the individual experience chronic pain, or complain of pain frequently?** □ Yes □ No *(If* ***NO****, skip to next section)* |
| **a.** Does the individual urinate more  frequently than appears normal?  □ Yes □ No | **a.** Has the individual ever taken or been  prescribed medication for pain?  □ Yes □ No If yes, please indicate the type:  □ Cannabis  □ Opioids  □ Other (list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**b.** Describe the location and intensity of the  pain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **b.** Does the individual seem to have an  increased thirst, compared to other  in the same age range? □ Yes □ No |
| **c.** Does the individual have any special  dietary instructions related to his/her  blood sugar? □ Yes □ No |
| **d.** Does the individual take any  medication to control his/her blood  sugar? □ Yes □ No |  |
| **SEXUAL RISK BEHAVIORS:** **Is the Individual sexually active?** □ Yes □ No *(If* ***NO****, skip to next section)* | **FEMALE REPRODUCTIVE HEALTH:** *(If the individual is male, or if the female has not had her first period, skip to next section)* |
| **a.** Does the individual use any  protection against sexually  transmitted diseases/infections  (STDs/STIs) when engaged in  sexual activity? | **a.** Does the individual see a women’s  health provider?  □ Yes – date of last visit: \_\_\_\_\_  □ No – referral needed **b.** Is the individual experiencing any issues  related to her menstrual cycle or  menopause? □ Yes □ No  If yes, describe: \_\_\_\_\_\_\_**c.** Is the individual currently or has the  individual ever been pregnant? □ Yes – currently □ Yes – previously  □ No If yes, describe the status or  outcome of the pregnancy. |
| **b.** When was the individual last tested  for STDs/STIs? \_\_\_\_\_\_\_  |
| **c.** Has the individual ever been  diagnosed with an STD/STI or HIV?  □ Yes □ No If yes, list the diagnosis and the age  of occurrence. \_\_\_\_\_\_ |
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| **21. DEVELOPMENTAL HISTORY** **Complete this section based on the individual’s early childhood experience** |
| **a.** Did the individual’s mother receive  the appropriate prenatal care? □ Yes □ No □ Unknown | **e.** Were there any unusual issues related to  the mother’s labor and delivery? □ Yes (describe below) □ No □ Unknown |
| **b.** Were there any complications during  the mother’s pregnancy? □ Yes □ No □ Unknown | **f.** What was the individual’s birth weight?  \_\_\_\_\_\_\_\_ |
| **c.** Was the individual’s birth normal or  premature? □ Yes □ No □ Unknown | **g.** When did the individual first crawl? \_\_\_\_ Walk? \_\_\_\_ Talk? \_\_\_\_ |
| **d.** Was the individual exposed to the  mother’s use of tobacco, alcohol, or  street/prescription drugs during  pregnancy? □ Yes □ No □ Unknown | **h.** When did the individual begin toilet  training? \_\_\_\_\_**i.** Does the individual have a biological  parent or sibling that has developmental  or behavioral problems? □ Yes □ No □ Unknown \_\_\_\_\_ |
| **Supporting Information:** Provide additional information on the individual’s social/developmental history, including significant events in prenatal/birth/early childhood stages, enduring physical/medical conditions, and pervasive developmental or cognitive difficulties. |
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| **22. MEDICAL HISTORY** |
| **How many times has the individual been to the Emergency Room in the past 12 months?** □ 0 □ 1 time □ 2 times □ 3 times □ 4+ times |
| What was the reason for the ER visit(s)? |
| **Has the individual ever been psychiatrically hospitalized?** □ No □ Yes *(if YES, please list below. Attach additional pages as needed.)* |
| **Hospital Name** | **Location****(City, State)** | **Dates Hospitalized** | **Reason(s)** |
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| **List all hospitalizations the individual has experienced. Attach additional pages as needed.** □ N/A |
| **Hospital Name** | **Location****(City, State)** | **Dates Hospitalized** | **Reason(s)** |
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| **List the names and specialties of the providers currently providing medical treatment to the individual. Attach additional pages as needed.** |
| **Provider Name** | **Specialty** | **Service(s) Provided** |
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| **Supporting Information:** Describe any other significant medical problems, treatments, hospitalizations, and outcomes not addressed above. |
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