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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:**      | **Date of Birth:**      | **Gender:** |
| **Height:** | **Weight:** | **Primary Care Doctor’s Name:**  | **Date of Last Physical Exam:** | **Date of Last Flu Shot:** |
|       ft.       in. |       lbs. |        |       [ ]  Visit due |        |

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| **19. MEDICATION(S)** List current and previous medications below, including over-the-counter medications. Attach additional pages as needed. |
| **Is the individual currently taking any psychotropic medications?**  | [ ]  Yes  | [ ]  No  |  **CANS Rating – Medication Compliance:**        |
|  | If **yes**, does the individual regularly receive lab work?  | [ ]  Yes  | [ ]  No  | [ ]  Not required | [ ]  Unknown |
| **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 If **yes**, describe:      |
| [ ]  0-1 | [ ]  2-3 | [ ]  More than 4 |  |
| **c. How many servings of fruits and vegetables does the individual usually eat in a day?** | **h. Does the individual have any allergies?** [ ]  Yes [ ]  No If **yes**, list:      |
| [ ]  0-1 | [ ]  2-3 | [ ]  More than 4 |  |
| **d. Does the individual engage in physical activity?** [ ]  Yes [ ]  No  | **i. Has the individual fallen in the past 12 months?** [ ]  Yes [ ]  No  |
| If **yes**, how often?       | 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 [ ]  N/A |
| **HEALTH CONCERNS:** Does the individual have any current healthconcerns? [ ]  Yes [ ]  No If **yes**, describe below. | **GENERAL ILLNESS:** Does the individual have a tendency to any illnesses [ ]  Yes [ ]  No If **yes**, describe below. |
|       |       |
| **BREATHING ISSUES:** Does the individual have any trouble breathing?  | **COGNITIVE ASSESSMENT:** *(skip if the individual is* ***under age 50)*** |
| [ ]  Yes [ ]  No *(if* ***NO****, skip to next section)* | a. Has the individual ever had a significant head injury? [ ]  Yes [ ]  No  If **yes**, when?     b. Does the individual have any difficulty remembering or recalling events?  [ ]  Yes [ ]  No c. Can the individual correctly tell you what year, month, and day it is?[ ]  Yes [ ]  No  |
| a. What are the breathing issues related to? Check all that apply. [ ]  Physical activity [ ]  Weather extremes [ ]  Other:      b. Does the individual take medication for breathing issues?  [ ]  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 b. Does the individual seem to have an increased thirst, compared  to others in the same age range? [ ]  Yes [ ]  No c. Does the individual have any special dietary instructions related  to his/her blood sugar? [ ]  Yes [ ]  No  If **yes**, describe:      d. Does the individual take any medication to control his/her blood  sugar? [ ]  Yes [ ]  No  |
| 1. Has the individual ever taken or been prescribed medication for pain? [ ]  Yes [ ]  No

If **yes,** indicate the type: [ ]  Cannabis [ ]  Opioids [ ]  Other (list):       1. Describe the location and intensity of the pain.
 |
| **SEXUAL RISK BEHAVIORS:** Is the individual sexually active? [ ]  Yes [ ]  No (*if* ***NO,*** *skip to next section)* | **FEMALE REPRODUCTIVE HEALTH:** *(if the individual is a* ***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?  [ ]  Yes [ ]  Sometimes [ ]  Noc. When was the individual last tested for STDs/STIs?      d. Has the individual ever been diagnosed with an STD/STI or HIV?  [ ]  Yes [ ]  No  If **yes**, list the diagnosis and the age of occurrence.       | 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 the outcome of the pregnancy.       |

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| **21. DEVELOPMENTAL HISTORY** Complete this section based on the individual’s early childhood experiences. |
| a. Did the individual’s mother receive the appropriate prenatal care?  [ ]  Yes [ ]  No [ ]  Unknown b. Were there any complications during the mother’s pregnancy?  [ ]  Yes (describe below) [ ]  No [ ]  Unknown c. Was the individual’s birth normal or premature?  [ ]  Normal [ ]  Premature [ ]  Unknown d. Was the individual exposed to the mother’s use of tobacco,  alcohol, or street/prescription drugs during pregnancy?  [ ]  Yes (describe below) [ ]  No [ ]  Unknown  | e. Were there any unusual issues related to the mother’s labor and  delivery? [ ]  Yes (describe below) [ ]  No [ ]  Unknown f. What was the individual’s birth weight?       g. When did the individual first crawl?       Walk?       Talk?      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 additional 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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