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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. |
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| **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  No  c. 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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