|  |
| --- |
| Initial  Update (recommended annually) |

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

**Addendum 2 – Health Risk Assessment (HRA)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **21. GENERAL INFORMATION (HRA)** | | | | | | | | | |
| **First Name:** | | **Last Name:** | | **Chosen/Preferred Name:** | | | **Pronouns:** | | **RIN:** |
| **Date of Birth:** | **Sex at Birth:** | | **Gender Identity:** | | **Height:**        ft.       in. | **Weight:**        lbs. | | **Date of Last Physical Exam:**  Visit due | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **22. MEDICATION(S)**  List current and previous medications below, including over-the-counter medications. Attach additional pages as needed. | | | | | |
| **Is the customer currently taking any psychotropic medications?**  Yes  No | | | | | |
| **Medication Name** | **Prescriber** | **Dosage** | **Date Started** | **Date Ended** | **Medication Side Effects** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |
| --- |
| **23. HEALTH STATUS** |
| a. Does the customer have any allergies?  Yes  No If yes, list:  b. Does the customer want help to quit smoking?  Yes  No  N/A – does not smoke  c. Has the customer fallen in the past 12 months?  Yes  No  N/A – age under 50 |
| **REPRODUCTIVE HEALTH:** *(skip to next section if the customer does not have periods)* |
| 1. Does the customer see a reproductive health provider (i.e. OB/GYN)?  Yes - date of last visit:        No - referral needed 2. Is the customer experiencing any issues related to their menstrual cycle or menopause?  Yes  No   If **yes**, describe.   1. Has the customer ever been pregnant?  Yes – currently  Yes – previously  No   If **yes**, describe the status or the outcome of the pregnancy.   1. Has the customer ever been diagnosed with an STD/STI?  Yes  No  Unknown   If **yes**, is a referral for specialized care needed?  Yes  No  Unknown |
| **CHRONIC PAIN:** Does the customer experience chronic pain or complain of pain frequently? Yes  No *(if* ***NO****, skip this section)* |
| 1. Has the customer 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. |
| **BLOOD SUGAR/DIABETES:** |
| 1. Does the customer urinate more frequently than appears normal?  Yes  No 2. Does the customer seem to have an increased thirst compared to others in the same age range?  Yes  No 3. Is the customer compliant with any dietary restrictions related to their blood sugar?  Yes  No  N/A   If **yes**, describe:  d. What was the customer’s last tested A1C level?  N/A A1C level:       Date of A1C test: |

|  |
| --- |
| **ADDITIONAL RELEVANT HEALTH INFORMATION:** |
|  |

|  |
| --- |
| **24. DEVELOPMENTAL HISTORY** *(skip to the next section if the customer is 21 years of age or older)* |
| a. Was the customer’s birth premature?  Yes  No  Unknown  b. Was the customer exposed to the mother’s use of tobacco, alcohol, or street/prescription drugs during pregnancy?  Yes (describe below)  No  Unknown  c. Were there any unusual issues related to the mother’s labor and delivery?  Yes (describe below)  No  Unknown |
| **Supporting Information:** Provide additional information on the customer’s social/developmental history, including significant events in prenatal/birth/early childhood stages, enduring physical/medical conditions, and pervasive developmental or cognitive difficulties. |
|  |

|  |
| --- |
| **25. MEDICAL HISTORY** |
| **How many times has the customer been to the Emergency Room in the past 12 months?**  0 times  1 time  2 times  3 times  4+ times |
| What was the reason for the ER visit(s)? |
| **Has the customer ever been psychiatrically hospitalized?**  No  Yes (*If* ***YES****, please describe below. Attach additional pages as needed.)* |
|  |
| **Has the customer ever been medically hospitalized?**  No  Yes (*If* ***YES****, please describe below. Attach additional pages as needed.)* |
|  |
| **Supporting Information:** Describe any other significant medical problems, treatments, hospitalizations, and outcomes not addressed above. |
|  |