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| [ ]  Initial [ ]  Update (recommended annually)  |

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

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

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| **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 |

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| **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** |
|       |       |       |       |       |       |
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| **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 smokec. 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:        |

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

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| **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. |
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| **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. |
|       |