Sonder Health
A Medicare Advantage Company

Health Risk Assessment

Name		SHP ID Number	
Phone Number(s)		Date	

Dear Member:

This assessment is designed to provide Sonder Health Plans with some important health information. The information that we request will help us understand and assist you with your individual healthcare needs. The information you provide is part of your personal health information. This information is held in strict confidence and privacy and will NOT be shared or released to anyone other than your treating physician(s) without your written consent.

Medical history

1. In general, would you say your health is:
   - ☐ Excellent
   - ☐ Very Good
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

2. Are you currently receiving treatment for, or have you received treatment in the past, for any of the following conditions?

Cancer, excluding pre-cancer conditions or in-situ status	□ YES □ NO	Stroke	□ YES □ NO
Severe hematologic disorders: i. Aplastic anemia ii. Hemophilia iii. Immune thrombocytopenic purpura iv. Myelodysplastic syndrome v. Sickle-cell disease (excluding sickle-cell trait) vi. Chronic venous thromboembolic disorder	□ YES □ NO	Chronic and disabling mental health conditions: i. Bipolar disorders ii. Major depressive disorders iii. Paranoid disorder iv. Schizophrenia v. Schizoaffective disorder	□ YES □ NO
Congestive Heart Failure	□ YES □ NO	HIV/AIDS	□ YES □ NO

Cardiovascular disorders: i. Cardiac arrhythmias ii. Coronary artery disease iii. Peripheral vascular disease iv. Chronic venous thromboembolic disorder	□ YES □ NO	Chronic Lung Disease: i. Asthma ii. Chronic bronchitis iii. Emphysema iv. Pulmonary fibrosis v. Pulmonary hypertension	□ YES □ NO
Diabetes mellitus	□ YES □ NO	End-Stage renal disease requiring dialysis	□ YES □ NO
Dementia	□ YES □ NO	End-stage Liver disease	□ YES □ NO
Neurologic disorders: i. Amyotrophic lateral sclerosis (ALS) ii. Epilepsy iii. Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia) iv. Huntington's disease v. Multiple sclerosis vi. Parkinson's disease vii. Polyneuropathy viii. Spinal stenosis ix. Stroke-related neurologic deficit	□ YES □ NO	Autoimmune disorders : i. Polyarteritis nodosa ii. Polymyalgia rheumatica iii. Polymyositis iv. Rheumatoid arthritis v. Systemic lupus erythematosus	□ YES □ NO
Chronic alcohol and other drug dependence	□ YES □ NO		

3. Current height and weight:

Height	__ft. __in.
Weight	lbs.

4. How many different prescription medications do you take every day?
   - None
   - 1 to 5 medications
   - 6 or more medications

Pain assessment

5. If you are currently bothered with pain, please tell us how bad the pain is, with 1 being very little pain, 5 being moderate pain, and 10 being severe pain:
   - ☐ I have no pain
   - ☐ 1 to 3
   - ☐ 4 to 6
   - ☐ 7 to 10

Nutrition

6. How many portions of fruits and vegetables do you eat daily?
   - ☐ Less than four portions of fruits and vegetables per day
   - ☐ Four or more portions of fruits and vegetables per day

7. Do you eat or drink two or more of the following: donuts, cakes, cookies, desserts, carbonated and fruit drinks in one day?
   - ☐ Yes
   - ☐ No

8. In the last 12 months*, did you ever eat less than you felt you should because there wasn't enough money for food?*
   - ☐ Yes
   - ☐ No

Substance Use

9. In the last 30 days, have you used tobacco?
   - ☐ No
   - ☐ Yes

10. How many times in the past 6 months have you had 4 or more drinks in a day?
    - ☐ None
    - ☐ 1
    - ☐ 2
    - ☐ 3 or more times

11. Do you use illegal drugs/substances?
    - ☐ No
    - ☐ Yes

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Activities of daily living

12. Do you need any help with the following:

☐ Bathing
☐ Dressing
☐ Use the bathroom
☐ Walking
☐ Taking medications
☐ Grocery Shopping
☐ Meal preparation
☐ Housekeeping
☐ Managing your finances

Abuse / Neglect

13. Do you currently (now) feel threatened or that you are being physically, mentally, or sexually abused?
    - ☐ Yes
    - ☐ No

14. Has anyone close to you failed to give you the care that you need?
    - ☐ Yes
    - ☐ No

Behavioral Health / Cognitive status

15. Over the past two weeks, how often have you felt little pleasure or no interest indoing things?
    - ☐ Not at all
    - ☐ Several days
    - ☐ More than 7 days
    - ☐ Everyday

16. In the past two weeks, how often have you felt down, depressed, or hopeless?
    - ☐ Not at all
    - ☐ Several days
    - ☐ More than 7 days
    - ☐ Everyday

17. Have any friends or family members expressed concerns about your memory?
    - ☐ Yes
    - ☐ No

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Socioeconomic Data

18. What is your primary race and/or ethnicity?
    - ☐ African American/Black
    - ☐ White
    - ☐ Asian/Pacific Islander
    - ☐ Native American/ Alaskan Native
    - ☐ Hispanic
    - ☐ Prefer not to answer
    - ☐ Other

19. What is your highest level of education?
    - ☐ Did not graduate from high school
    - ☐ High school graduate
    - ☐ College
    - ☐ Graduate school

20. What is your annual Household Income?
    - ☐ Less than $10,000
    - ☐ $10,000-$19,999
    - ☐ $20,000-$29,999
    - ☐ $30,000-$49,999
    - ☐ $50,000 or More
    - ☐ Don't know

21. Who do you live with and where?
    - ☐ Alone
    - ☐ Homeless
    - ☐ Institution Long-term care
    - ☐ In a senior housing or assisted-living apartment
    - ☐ Live with Child
    - ☐ Live with Family/Parent
    - ☐ Live with Friends
    - ☐ Spouse
    - ☐ Caregiver
    - ☐ Other: _____

22. Are you worried that in the next 2 months, you may not have stable housing?*
    - ☐ Yes
    - ☐ No

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Transportation

23. In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?*
    - ☐ Yes
    - ☐ No

Preventive Care

24. Within the past 12 months have you had any of the following (check all that apply)?
    - ☐ Annual physical exam or wellness visit
    - ☐ Colorectal cancer screening
    - ☐ Cervical cancer screening
    - ☐ Breast cancer screening
    - ☐ Influenza vaccination
    - ☐ Pneumonia vaccination
    - ☐ Complete eye exam with having eyes dilated
    - ☐ None

DME

25. Do you currently use any of the following special DME equipment / supplies (check all that apply)?
    - ☐ CPAP machine
    - ☐ Oxygen
    - ☐ Electric bed
    - ☐ Wheelchair or motorized mobility device
    - ☐ Other:_____

Living will / Durable Power of Attorney

26. Do you have a living will or Durable Power of Attorney for healthcare?
    - ☐ Yes: Name_____/ Ph#: _____/
      Email address_____
    - ☐ No

Please sign, print, and date on the line below. If someone other than the member is completing the form, please indicate the relationship to the member (e.g., Self, Spouse, etc.).

Return this form to us, or call Sonder Health Plans Member Services Department toll free at 1-888-428-4440 / (TTY/TDD 711) if you need help completing this form.

Signature: _____**Print Name:** _____

Relation:_____ **Date**: ___/___/_____

*Source: *Health Leads' screening toolkit*