california health & wellness

Health Information Form

Questions?

Call **877-658-0305 (TDD/TTY: 711)**

Visit **CAHealthWellness.com**

Please take a few minutes to fill out the form on the next page, or fill it out online – **CAHealthWellness.com**

This will help us identify any extra needs or services you may require. Please place this form in the provided postage paid envelope and drop in the mail.

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Your Personal Wellness Assessment

One Member Per Form

*Indicates Required Field

General Information

Member First Name

Member Last Name

*Date of Birth (MMDDYYYY)

*Medi-Cal ID

On what date are these questions being answered (MMDDYYYY)

Member Preferred Phone Number

Member Email Address

Global Health

In general, how would you rate your health?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Unknown

Do you have a doctor or health care provider? ☐ Yes ☐ No ☐ Unknown

Have you seen your doctor or health care provider in the last 12 months? ☐ Yes ☐ No ☐ Unknown

Do you ever have any problems with transportation to your medical appointments? ☐ Yes ☐ No ☐ Unknown

How many times have you been in the hospital in the last 3 months?

☐ None ☐ One time ☐ Two times ☐ Three or more times ☐ Unknown

How many times have you been in the Emergency Department in the last year?

☐ None ☐ One time ☐ Two times ☐ Three or more times ☐ Unknown

How many medicines are you currently taking that were prescribed by your doctor or health care provider?

☐ 0 ☐ 1-3 ☐ 4-7 ☐ 8-14 ☐ Greater than or equal to 15 ☐ Unknown

What is your height (enter response in feet/inches)?

Feet ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ Unknown

Inches ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ Unknown

What is your weight (enter response in pounds)?

Have you received a flu shot in the last 12 months? ☐ Yes ☐ No ☐ Unknown

Do you have problems with your teeth or mouth that make it hard for you to eat? ☐ Yes ☐ No ☐ Unknown

Do you eat at least 2 meals per day? ☐ Yes ☐ No ☐ Unknown

Do you eat fruits and vegetables every day? ☐ Yes ☐ No ☐ Unknown

Do you participate in any physical activity (such as walking, water aerobics, bowling, etc.) during the week?

☐ Yes ☐ No ☐ I am unable to exercise due to medical conditions ☐ Unknown

Do you always use a seatbelt when you drive or ride in a car? ☐ Yes ☐ No ☐ N/A ☐ Unknown

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Member First Name

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Physical Health

Have you ever been told by a doctor or health care provider that you have any of these conditions? (Check all that apply)

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Chronic Kidney Disease
- ☐ COPD/ Emphysema
- ☐ Developmental Delay
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Pre-Diabetes
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV
- ☐ Sickle Cell Disease (not trait)
- ☐ Stroke
- ☐ Transplant

Do you have any other conditions not listed above? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No ☐ N/A

Behavioral Health

In general, how satisfied are you with your life?

☐ Very Satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied ☐ Unknown

In the past two weeks have you been bothered by any of the following problems?

Feeling Lonely

☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day ☐ Unknown

Little interest or pleasure in doing things

☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day ☐ Unknown

Feeling down, depressed or hopeless

☐ Not at all ☐ Several Days ☐ More than half the days ☐ Nearly every day ☐ Unknown

Over the past month (30 days), how many days have you felt lonely

☐ None - I never feel lonely ☐ Less than 5 days ☐ More than half the days (more than 15) ☐ Most Days - I always feel lonely

Do you feel the stress in your life is affecting your health? ☐ Yes ☐ No ☐ Unknown

What are your plans for managing stress? ☐ No changes needed ☐ No plan to change

☐ Started making changes ☐ Plan to change in the next month ☐ Plan to change in next 6 months ☐ Unknown

During the past year, how often did you have 5 or more alcoholic drinks in one day?

☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐ Unknown

During the past year, how often did you use tobacco products?

☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐ Unknown

Have you been diagnosed with a behavioral health disorder like anxiety, depression, bipolar or schizophrenia?

☐ Yes ☐ No ☐ Unknown

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Behavioral Health Continued

Have you been prescribed anti-psychotic medication within the past 90 days? ☐ Yes ☐ No ☐ Unknown

Activities of Daily and Independent Living

During the last month, have you had pain that interfered with completion of housework or your ability to work outside the home? ☐ Yes ☐ No ☐ Unknown

Do you have a caregiver who helps you on a regular basis? ☐ Yes ☐ No ☐ Unknown

Do you use any assistive devices? ☐ Yes ☐ No ☐ Unknown

Have you used oxygen in the last 90 days? ☐ Yes ☐ No ☐ Unknown

Do you receive any home health services? ☐ Yes ☐ No ☐ Unknown

Do you need help with any of these actions? (Check Yes or No to each action)

Taking a bath or shower	☐ Yes ☐ No	Going Upstairs	☐ Yes ☐ No
Eating	☐ Yes ☐ No	Getting dressed	☐ Yes ☐ No
Brushing Teeth, brushing hair, shaving	☐ Yes ☐ No	Making meals or cooking	☐ Yes ☐ No
Getting out of a bed or chair	☐ Yes ☐ No	Shopping and getting food	☐ Yes ☐ No
Using the toilet	☐ Yes ☐ No	Walking	☐ Yes ☐ No
Washing dishes or clothes	☐ Yes ☐ No	Writing checks or keeping track of money	☐ Yes ☐ No
Getting a ride to the doctor or to see your friends	☐ Yes ☐ No	Doing house or yard work	☐ Yes ☐ No
Going out to visit family or friends	☐ Yes ☐ No	Using the Phone	☐ Yes ☐ No
Keeping track of appointments	☐ Yes ☐ No	If yes, are you getting all the help you need with these actions	☐ Yes ☐ No

**In the past two months have you been living in stable housing that you own, rent or stay in as part of a household? ☐ Yes ☐ No ☐ Unknown

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Activities of Daily and Independent Living Continued

Can you live safely and move easily around in your home? ☐ Yes ☐ No

If No, does the place where you live have:

Good lighting?	☐ Yes	☐ No	Good heating?	☐ Yes	☐ No
Good cooling?	☐ Yes	☐ No	Rails for any stairs or ramps?	☐ Yes	☐ No
Hot Water?	☐ Yes	☐ No	Indoor Toilet?	☐ Yes	☐ No
A door to the outside that locks?	☐ Yes	☐ No	Stairs to get into your home or stairs inside your home?	☐ Yes	☐ No
Elevator?	☐ Yes	☐ No	Space to use a wheelchair?	☐ Yes	☐ No
Clear ways to exit your home?	☐ Yes	☐ No			

I would like to ask you about how you think you are managing your health conditions

Do you need help taking your medicines?	☐ Yes	☐ No
Do you need help filling out health forms?	☐ Yes	☐ No
Do you need help answering questions during a doctor's visit?	☐ Yes	☐ No
Do you have family members or others willing and able to help you when you need it?	☐ Yes	☐ No
Do you ever think your caregiver has a hard time giving you all the help you need?	☐ Yes	☐ No
Are you afraid of anyone or is anyone hurting you?	☐ Yes	☐ No
Have you had any changes in thinking, remembering, or making decisions?	☐ Yes	☐ No
Have you fallen in the last month?	☐ Yes	☐ No
Are you afraid of falling?	☐ Yes	☐ No
Do you sometimes run out of money to pay for food, rent, bills and medicine?	☐ Yes	☐ No
Is anyone using your money without your ok?	☐ Yes	☐ No
Would you like to work with a nurse or social worker to make a plan for your healthcare?	☐ Yes	☐ No
Would you like to talk with a nurse or social worker and your doctor about a plan to meet your healthcare needs?	☐ Yes	☐ No

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