

## 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.

18. GENERAL INFORMATION (HRA)				
Staff Name:	Individual First and Last Name:	RIN:	Date of Birth:	Gender:
Height: _____ ft. _____ in.	Weight: _____ lbs.	Primary Care Doctor's Name:	Date of Last Physical Exam: _____ <input type="checkbox"/> Visit due	Date of Last Flu Shot: _____

19. MEDICATION(S) List current and previous medications below, including over-the-counter medications. Attach additional pages as needed.					
<b>Is the individual currently taking any psychotropic medications?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>CANS Rating – Medication Compliance:</b> _____ If <b>yes</b> , does the individual regularly receive lab work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required <input type="checkbox"/> Unknown					
Medication Name	Prescriber	Dosage	Date Started	Date Ended	Medication Issues

20. HEALTH STATUS		CANS Rating – Medical/Physical: _____
<b>a. Individual's self-report on general physical health:</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <b>b. How many snack foods or drinks (e.g., chips, cookies, candy, soda) does the individual usually consume in a day?</b> <input type="checkbox"/> 0-1 <input type="checkbox"/> 2-3 <input type="checkbox"/> More than 4 <b>c. How many servings of fruits and vegetables does the individual usually eat in a day?</b> <input type="checkbox"/> 0-1 <input type="checkbox"/> 2-3 <input type="checkbox"/> More than 4 <b>d. Does the individual engage in physical activity?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , how often? _____ <b>e. Does the individual use any form of tobacco?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>f. Does the individual drink alcohol?</b> If <b>yes</b> , how often and how much? _____ <b>g. Has the individual ever fainted or passed out?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , describe: _____ <b>h. Does the individual have any allergies?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , list: _____ <b>i. Has the individual fallen in the past 12 months?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , describe: _____ <b>j. Does the individual want help to quit smoking?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
<b>HEALTH CONCERNS:</b> Does the individual have any current health concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , describe below.	<b>GENERAL ILLNESS:</b> Does the individual have a tendency to any illnesses <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , describe below.	
<b>BREATHING ISSUES:</b> Does the individual have any trouble breathing? <input type="checkbox"/> Yes <input type="checkbox"/> No (if <b>NO</b> , skip to next section) <b>a.</b> What are the breathing issues related to? Check all that apply. <input type="checkbox"/> Physical activity <input type="checkbox"/> Weather extremes <input type="checkbox"/> Other: _____ <b>b.</b> Does the individual take medication for breathing issues? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>COGNITIVE ASSESSMENT: (skip if the individual is under age 50)</b> <b>a.</b> Has the individual ever had a significant head injury? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , when? _____ <b>b.</b> Does the individual have any difficulty remembering or recalling events? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>c.</b> Can the individual correctly tell you what year, month, and day it is? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>BLOOD SUGAR/DIABETES:</b> <b>a.</b> Does the individual urinate more frequently than appears normal? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>b.</b> Does the individual seem to have an increased thirst, compared to others in the same age range? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>c.</b> Does the individual have any special dietary instructions related to his/her blood sugar? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , describe: _____ <b>d.</b> Does the individual take any medication to control his/her blood sugar? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>CHRONIC PAIN:</b> Does the individual experience chronic pain, or complain of pain frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No (if <b>NO</b> , skip to next section) <b>a.</b> Has the individual ever taken or been prescribed medication for pain? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , indicate the type: <input type="checkbox"/> Cannabis <input type="checkbox"/> Opioids <input type="checkbox"/> Other (list): _____ <b>b.</b> Describe the location and intensity of the pain. _____	

<p><b>SEXUAL RISK BEHAVIORS:</b> Is the individual sexually active?  <input type="checkbox"/> Yes <input type="checkbox"/> No (if <b>NO</b>, skip to next section)</p> <p>a. Does the individual use any protection against sexually transmitted diseases/infections (STDs/STIs) when engaged in sexual activity?  <input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No</p> <p>c. When was the individual last tested for STDs/STIs? _____</p> <p>d. Has the individual ever been diagnosed with an STD/STI or HIV?  <input type="checkbox"/> Yes <input type="checkbox"/> No              If <b>yes</b>, list the diagnosis and the age of occurrence. _____</p>	<p><b>FEMALE REPRODUCTIVE HEALTH:</b> (if the individual is a <b>male</b>, or if the <b>female has not had her first period</b>, skip to next section)</p> <p>a. Does the individual see a women's health provider?  <input type="checkbox"/> Yes - date of last visit: _____ <input type="checkbox"/> No – referral needed</p> <p>b. Is the individual experiencing any issues related to her menstrual cycle or menopause? <input type="checkbox"/> Yes <input type="checkbox"/> No              If <b>yes</b>, describe. _____</p> <p>c. Is the individual currently or has the individual ever been pregnant?  <input type="checkbox"/> Yes – currently <input type="checkbox"/> Yes – previously <input type="checkbox"/> No              If <b>yes</b>, describe the status or the outcome of the pregnancy.</p>
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<b>21. DEVELOPMENTAL HISTORY</b>	
Complete this section based on the individual's early childhood experiences.	
<p>a. Did the individual's mother receive the appropriate prenatal care?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>b. Were there any complications during the mother's pregnancy?  <input type="checkbox"/> Yes (describe below) <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>c. Was the individual's birth normal or premature?  <input type="checkbox"/> Normal <input type="checkbox"/> Premature <input type="checkbox"/> Unknown</p> <p>d. Was the individual exposed to the mother's use of tobacco, alcohol, or street/prescription drugs during pregnancy?  <input type="checkbox"/> Yes (describe below) <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>e. Were there any unusual issues related to the mother's labor and delivery? <input type="checkbox"/> Yes (describe below) <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>f. What was the individual's birth weight? _____</p> <p>g. When did the individual first crawl? _____ Walk? _____ Talk? _____</p> <p>h. When did the individual begin toilet training? _____</p> <p>i. Does the individual have a biological parent or sibling that has developmental or behavioral problems?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<b>Supporting Information:</b> 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.	

<b>22. MEDICAL HISTORY</b>
<p><b>How many times has the individual been to the Emergency Room in the past 12 months?</b> <input type="checkbox"/> 0 <input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3 times <input type="checkbox"/> 4+ times</p> <p>What was the reason for the ER visit(s)?</p>

<b>Has the individual ever been psychiatrically hospitalized?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (if <b>YES</b> , please list below. Attach additional pages as needed.)			
Hospital Name	Location (City, State)	Dates Hospitalized	Reason(s)

<b>List all additional hospitalizations the individual has experienced. Attach additional pages as needed.</b> <input type="checkbox"/> N/A			
Hospital Name	Location (City, State)	Dates Hospitalized	Reason(s)

<b>List the names and specialties of the providers currently providing medical treatment to the individual. Attach additional pages as needed.</b>		
Provider Name	Specialty	Service(s) Provided

<b>Supporting Information:</b> Describe any other significant medical problems, treatments, hospitalizations, and outcomes not addressed above.