



SoonerCare Health Risk Assessment

DEMOGRAPHICS:

Patient Name: _____ **SoonerCare ID#:** _____

Assessment Date: ___/___/___ **Patient SSN:** _____

SoonerCare Status: _____

Age: _____ **Gender:** _____ **Date of Birth:** _____

Parent/Guardian: _____ **Home Phone #:** _____

Work Phone #: _____ **Cell Phone #:** _____

Pager #: _____ **Best Time to Call:** _____

Patient Address: _____
City State Zip Code

Emergency Contact: _____ **Phone #:** _____

Sources of Information (Ex: Emerging Asthma Report, Patient, Parent/Guardian, Referral, PCP/Other):

Patient's General Perception of Health:
(Poor, Fair, Good, Very Good, Excellent): _____ **Height:** _____
Weight: _____

Chief Complaint (Reason for Referral): _____

Comments: _____



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FAMILY/PERSONS LIVING IN THE HOME:

Name:	DOB:	Age:	Relationship	Sooner Care
_____	___/___/___	_____	_____	<input type="checkbox"/>
_____	___/___/___	_____	_____	<input type="checkbox"/>
_____	___/___/___	_____	_____	<input type="checkbox"/>
_____	___/___/___	_____	_____	<input type="checkbox"/>

Comments: _____

DISEASE MANAGEMENT/MEDICAL CONDITIONS:

(Ask about Hypertension, Heart Disease, and other clinical indicators related to identified conditions.)

Diabetes: Yes No

Comments: _____

Asthma: Yes No Stage _____

Comments: _____

COPD: Yes No

Comments: _____

CHF: Yes No

Comments: _____



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Obesity: Yes No

Comments: _____

OTHER MEDICAL CONDITIONS:

Condition: _____

Comments: _____

MEDICATIONS:

Any Drug Allergies Yes No If yes, describe: _____

Pharmacy (Most Frequently Used): _____



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Smoking: Yes No Number of Cigs: _____ Wants to Quit: Yes No
Exposure to Smoke: Yes No
Comments: _____

EPSDT/Well Child Checks Has Needs Date of Last Visit: ___/___/_____
Comments: _____

Specialists: Has Needs

1. _____ Date of Last Visit: ___/___/_____

Comments: _____

2. _____ Date of Last Visit: ___/___/_____

Comments: _____

3. _____ Date of Last Visit: ___/___/_____

Comments: _____

4. _____ Date of Last Visit: ___/___/_____

Comments: _____

General Notes:



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IMMUNIZATIONS/FLU SHOTS/OTHER:

Name:

_____	<input type="checkbox"/> Has <input type="checkbox"/> Needs	Last Date of: ___/___/___
_____	<input type="checkbox"/> Has <input type="checkbox"/> Needs	Last Date of: ___/___/___
_____	<input type="checkbox"/> Has <input type="checkbox"/> Needs	Last Date of: ___/___/___
_____	<input type="checkbox"/> Has <input type="checkbox"/> Needs	Last Date of: ___/___/___
_____	<input type="checkbox"/> Has <input type="checkbox"/> Needs	Last Date of: ___/___/___
_____	<input type="checkbox"/> Has <input type="checkbox"/> Needs	Last Date of: ___/___/___
_____	<input type="checkbox"/> Has <input type="checkbox"/> Needs	Last Date of: ___/___/___

SOCIAL ISSUES:

(Does patient or parent/guardian need parenting classes, or have other needs, i.e., child care, help with the care of medically fragile child, care for elderly parent or others living in the home?)

Financial/Legal: Yes No

Comments: _____

Housing: Yes No

Comments: _____

Educational Barriers/Literacy: Yes No

Comments: _____



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Environmental: Yes No

Comments: _____

Support System: Yes No

Comments: _____

Transportation: Yes No

Comments: _____

Family Issues: Yes No

Comments: _____

Inability to care for oneself: Yes No

Comments: _____

Food Stamps: Yes No

Comments: _____

Other Social Issue

Comments/Notes: _____



**SoonerCare
Health Risk Assessment**

MENTAL HEALTH (PATIENT):
(Any history of violence, abuse or neglect?)

Substance Abuse: Yes No
Comments: _____

ADHD/ADD: Yes No
Comments: _____

Depression: Yes No
Comments: _____

Patient has a mental health worker/counselor: Yes No
Name of counselor: _____

Other: Yes No
Comments: _____

MENTAL HEALTH (PARENT/GUARDIAN):
(Any history of violence, abuse or neglect?)

Substance Abuse: Yes No
Comments: _____



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ADHD/ADD: Yes No

Comments: _____

Depression: Yes No

Comments: _____

Patient has a mental health worker/counselor: Yes No

Name of counselor: _____

Other: Yes No

Comments: _____

FUNCTIONAL(PATIENT):
(Does patient/guardian need special services such as OT, PT, ST; Family Support Services, etc.)

Cognitive Impairment: Yes No

Severity of Patient's Cognitive Impairment: Unknown

Comments: _____

Motor Impairment: Yes No

Severity of Patient's Motor Impairment: Unknown

Comments: _____



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Other: Yes No

Comments: _____

FUNCTIONAL(PARENT/GUARDIAN):

(Does patient/guardian need special services such as OT, PT, ST; Family Support Services, etc.)

Cognitive Impairment: Yes No

Severity of Parent/Guardian's Cognitive Impairment: Unknown

Comments: _____

Motor Impairment: Yes No

Severity of Parent/Guardian's Motor Impairment: Unknown

Comments: _____

Other: Yes No

Comments: _____

UTILIZATION ISSUES:

Adherence Issues: Yes No

Comments: _____

ED Visits: Yes No Diagnosis: _____ Date of Last Visit: ___/___/___

Comments: _____



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Health Insurance/Access: Yes No

Comments: _____

Hospital (IP): Yes No **Diagnosis:** _____ **Date of Last Visit:** ___/___/___

Comments: _____

High Cost/High Risk: Yes No

Comments: _____

Pharmacy Issues: Yes No

Comments: _____

General Comments/Notes:

**OTHER AGENCIES OR PEOPLE CURRENTLY HELPING
PATIENT/FAMILY?**

Name/Agency:	Type of Assistance:	Phone:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Completed by: _____ **Date:** ___/___/___

- Initial Assessment
- Updated Assessment