Community Care Alliance of Illinois

Initial Health Risk Survey

Thank you for taking the time to complete this survey. The answers you give will be shared with your doctor and will help you get proper health care in a timely manner. Filling out this survey will not affect your status in CCAI. Be sure to send us your completed survey as soon as possible. If you need help completing this survey please call our Member Services Department at 1-866-871-2305; we will be glad to help you.

Demographics

Name:_____ Case #: _____ DOB: _____

Street Address: _____ City: _____ Zip Code: _____

Home Ph #: _____ Cellular Ph #: _____ Work Ph #: _____

Email Address: _____

Person completing the survey

❑ Myself ❑ Other If other: Name: _____

Someone who can find me: _____ Phone/Cell:_____

Other: _____ Phone/Cell:_____

1. **What is your primary language?**
   ❑ English ❑ Spanish ❑ Other: _____
2. **Do you have any health concerns that need immediate attention?**
   ❑ Yes ❑ No If yes, please explain: _____
3. **In the past year, how many times did you go to the Emergency Room?** _____
4. **In the past year, how many times were you admitted to the hospital?** _____
5. **How many prescription medications do you take daily?**
   ❑ 0 ❑ 1-2 ❑ 3-4 ❑ 5 or more
6. **Do you need a care giver?**
   ❑ Yes ❑ No
   If yes, is someone available to you? ❑ Yes ❑ No

Please call Member Services Department at 1-866-871-2305 to complete by phone or mail the completed form to: Community Care Alliance of Illinois, 322 S. Green Street, Suite 400, Chicago, IL 60607. You can also fax it to 312-492-9707.

7. Do you use any devices to help you with? (Check all that apply)

❑ Breathing ❑ Mobility ❑ Feeding ❑ Ventilator ❑ Communication ❑ Urination ❑ Dialysis

❑ Other: _____

8. Do you have any of the following conditions? (circle all that apply)

Asthma	Heart Disease	Cerebral Palsy	Incontinence-Bladder
Diabetes	Chest Pain	Traumatic Brain Injury	Blind/Low Vision
High Blood Pressure	Cancer Type:_____	Arthritis	Multiple Sclerosis
Stroke	Seizures	Dialysis	Thyroid Disease
Lung Disease	Mental Illness	Bed/Pressure Sores	Substance Abuse
Dementia/Alzheimer's Disease	Spinal Cord Injury	History of Broken Bones	Hemophilia
Kidney Disease	Amputation Type: _____	Gastrointestinal Problems	Sickle Cell Anemia
Liver Problems	Spina Bifida	Deaf/Hard of Hearing	
Transplant Type:_____	Parkinson's Disease	Incontinence-Bowel	

Other:_____

Other:_____

9. What is your current living situation (please circle)?

Homeless	Live Alone	Live with Others Unrelated	Live with other Family
Live in a Shelter	Live with Spouse	Live in a Group Home	Live in a Nursing Home
Live in Assisted Living Facility			

Other:_____

10. Are you able to afford basic needs, medical care and medications?

❑ Yes ❑ No

11. In the past year, have you experienced or witnessed any form of violence, abuse or neglect?

❑ Yes ❑ No

12. Do you need any of the following accommodations for your medical appointments?

Wheel Chair Accessible examination table, scale or a lift.

❑ Yes ❑ No

If Yes, please which one _____

Interpreter:_____

Communication Aides: _____

Transportation: _____

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