HEALTH NEEDS QUESTIONNAIRE (HNQ) / HEALTH RISK ASSESSMENT (HRA)

This Health Needs Questionnaire will assist Community Care Plan and your doctor(s) understand your medical needs and ensure continuity of your care. If you need help completing this form, please call us at 866-224-5701. The information is kept CONFIDENTIAL.

After completing the Health Needs Questionnaire, place in a sealed envelope and drop in the designated area located by the employee mailboxes.

Name of Person completing this form	
Employee ID #	
Member Name, First and Last	
Member Date of Birth	
Gender	☐ Male ☐ Female
Member Address	
Member Contact Information	Home Phone: Cell Phone: Work Phone: Email: _____
Preferred Mode of Contact	☐ Home ☐ Work ☐ Cell ☐ Email
Name of Primary Care Physician (PCP)	
Physician (PCP) Phone	
When was your last Well Exam with your PCP completed?	

1. Has a doctor ever told you that you have any of the following? (please check all that apply)	☐ Pre-Diabetes/Diabetes ☐ High Blood Pressure ☐ Asthma ☐ COPD ☐ High-Risk Pregnancy ☐ Heart Disease ☐ Sickle Cell ☐ Cancer ☐ Kidney Disease ☐ Depression Other: _____

2. Are you currently undergoing any treatments or therapies? (i.e. chemotherapy, dialysis, physical or speech therapy etc.) ☐ Yes ☐ No	If yes, provider name _____ Expected date of completion _____
3. Are you scheduled for any surgeries? ☐ Yes ☐ No 4. If yes, what procedure(s)?	Surgery date:_____ Surgeon's name: _____ Scheduled location: _____
5. Please list all medications you are on (include prescription drugs, and others such as aspirin, Tylenol, vitamins, nose sprays, etc.)	List medications:
6. Do you have any allergies? If so, please list ☐ Yes ☐ No	List Allergies:
7. Are you receiving any home health care? ☐ Yes ☐ No 8. If yes: Type_____ Frequency: _____	Agency Name: _____ Agency phone number: _____
9. Do you use any medical equipment in your home? ☐ Yes ☐ No Please list equipment(s): _____	If yes, name of provider? _____ Provider Phone: _____

If you are a male, or filling out this form for a male enrollee, please go to number 13.

10. Are you now or think you may be pregnant?	☐ Yes ☐ No
11. Are you receiving prenatal care?	☐ Yes ☐ No
12. Who is your Obstetrician? _____	Due date: _____
13. Do you have any other health needs or concerns that have not been addressed on this form? If so, please list:	

This information is available for free in other languages. Please contact our customer service number at 1-866-224-5701.