health net

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

Rev. 04 12 2022
XC-HIF-2109

Member First Name

Member Last Name

*Date of Birth (MMDDYYYY)

*Medi-Cal ID

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

Rev. 04 12 2022
XC-HIF-2109-2

Member First Name

Member Last Name

*Date of Birth (MMDDYYYY)

*Medi-Cal ID

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

**Reprinted with permission from the copyright holder, the American Public Health Association. Montgomery AE, Fargo JD, Byrne TH, Kane V, Culhane DP. Universal screening for homelessness and risk for homelessness in the Veterans Health Administration. American Journal of Public Health. 2013; 103 (S2): S201–S211. Permission obtained.

Rev. 04 12 2022
XC-HIF-2109-3

Member First Name

Member Last Name

*Date of Birth (MMDDYYYY)

*Medi-Cal ID

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