

Health Risk Behavior Assessment

Name _____

Date Of Birth _____

ID# _____

| Please answer the following questions so that we can take better care of you! Please be honest; circle your response or fill in blank after question! | | | | | | | INTERVENTION | | | |
|--|--|-------------------------|---------------------------|-------------------------|------------------------|-----------------|------------------|----|----|---|
| | | | | | | | D | NR | RX | R |
| 1. | What is your history of tobacco use? | <i>Cigarettes</i> | <i>pipes</i> | <i>cigars</i> | <i>chewing tobacco</i> | <i>none</i> | | | | |
| 2. | Are there smokers at home or in your work area? | | <i>yes</i> | | <i>no</i> | | | | | |
| 3. | How often do you drink alcohol? | <i>daily</i> | <i>weekly</i> | <i>monthly</i> | <i>never</i> | | | | | |
| 4. | What do you usually drink? _____ | | | | | | | | | |
| 5. | Do you drink alcohol and drive? | <i>yes</i> | | <i>sometimes</i> | <i>never</i> | | | | | |
| 6. | Do you use seatbelts? | <i>always</i> | | <i>sometimes</i> | <i>never</i> | | | | | |
| 7. | Do you use drugs not prescribed by a doctor (not including vitamins)? | | <i>yes</i> | <i>sometimes</i> | <i>never</i> | | | | | |
| 8. | What type of drugs? | <i>Heroin</i> | <i>Cocaine/Crack</i> | <i>LSD</i> | <i>Marijuana</i> | <i>other</i> | | | | |
| 9. | Do you drive while under the influence of these drugs? | | <i>yes</i> | <i>sometimes</i> | <i>never</i> | | | | | |
| 10. | What are your exercise habits? I exercise: | <i>every day</i> | <i>1-2 times per week</i> | <i>rarely</i> | | | | | | |
| 11. | In the past year, with how many people have you had sexual contact with? | <i>0</i> | <i>1</i> | <i>2-3</i> | <i>4 or more</i> | | | | | |
| 12. | Have you had sexual contact with anyone of the same sex? | | <i>yes</i> | | <i>no</i> | | | | | |
| 13. | Do you use latex condoms? | | <i>always</i> | <i>sometimes</i> | <i>never</i> | | | | | |
| 14. | What type of birth control do you use? _____ | | | | | | | | | |
| 15. | Do you follow a diet? | <i>No</i> | <i>Yes</i> | <i>low calorie</i> | <i>low fat</i> | <i>low salt</i> | <i>low sugar</i> | | | |
| 16. | Are you satisfied with your present weight? | | <i>yes</i> | | <i>no</i> | | | | | |
| 17. | How much did you weigh a year ago? | <i>5-10 pounds more</i> | <i>same</i> | <i>5-10 pounds less</i> | <i>other</i> | | | | | |
| 18. | Are there guns kept at home? | | <i>yes</i> | <i>sometimes</i> | <i>never</i> | | | | | |
| 19. | Do you feel safe at home? | | <i>yes</i> | <i>sometimes</i> | <i>never</i> | | | | | |
| 20. | Over the past year has anyone been abusive towards you or your family? | | <i>yes</i> | <i>maybe</i> | <i>no</i> | | | | | |

* **Physician initial and date appropriate column**

D=Discussed NR=Not at risk RX=Prescribed R=Referred

Initial/Signature: _____

ID# _____