HFS
Illinois Department of
Healthcare and Family Services

☐ Initial
☐ Update (recommended annually)

Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)
Addendum 1 – Health Risk Assessment (HRA)

18. GENERAL INFORMATION (HRA)

First Name:	Last Name:	Chosen/Preferred Name:	Pronouns:	RIN:

Date of Birth:	Sex at Birth:	Gender Identity:	Height: _____ ft. _____ in.	Weight: _____ lbs.	Date of Last Physical Exam: _____ ☐ Visit due

19. MEDICATION(S)

List current and previous medications below, including over-the-counter medications. Attach additional pages as needed.

Is the customer currently taking any psychotropic medications? ☐ Yes ☐ No

Medication Name	Prescriber	Dosage	Date Started	Date Ended	Medication Side Effects

20. HEALTH STATUS

a. Does the customer have any allergies? ☐ Yes ☐ No If yes, list: _____
b. Does the customer want help to quit smoking? ☐ Yes ☐ No ☐ N/A – does not smoke
c. Has the customer fallen in the past 12 months? ☐ Yes ☐ No ☐ N/A – age under 50

REPRODUCTIVE HEALTH: *(skip to next section if the customer does not have periods)*

a. Does the customer see a reproductive health provider (i.e. OB/GYN)? ☐ Yes - date of last visit: _____ ☐ No - referral needed
b. Is the customer experiencing any issues related to their menstrual cycle or menopause? ☐ Yes ☐ No
   If **yes**, describe. _____
c. Has the customer ever been pregnant? ☐ Yes – currently ☐ Yes – previously ☐ No
   If **yes**, describe the status or the outcome of the pregnancy. _____
d. Has the customer ever been diagnosed with an STD/STI? ☐ Yes ☐ No ☐ Unknown
   If **yes**, is a referral for specialized care needed? ☐ Yes ☐ No ☐ Unknown

CHRONIC PAIN: Does the customer experience chronic pain or complain of pain frequently? ☐ Yes ☐ No *(if **NO**, skip this section)*

a. Has the customer ever taken or been prescribed medication for pain? ☐ Yes ☐ No
   If **yes,** indicate the type: ☐ Cannabis ☐ Opioids ☐ Other (list): _____
b. Describe the location and intensity of the pain. _____

BLOOD SUGAR/DIABETES:

a. Does the customer urinate more frequently than appears normal? ☐ Yes ☐ No
b. Does the customer seem to have an increased thirst compared to others in the same age range? ☐ Yes ☐ No
c. Is the customer compliant with any dietary restrictions related to their blood sugar? ☐ Yes ☐ No ☐ N/A
   If **yes**, describe: _____
d. What was the customer's last tested A1C level? ☐ N/A A1C level: _____ Date of A1C test: _____

ADDITIONAL RELEVANT HEALTH INFORMATION:

21. DEVELOPMENTAL HISTORY *(skip to the next section if the customer is 21 years of age or older)*

a. Was the customer's birth premature? ☐ Yes ☐ No ☐ Unknown

b. Was the customer exposed to the mother's use of tobacco, alcohol, or street/prescription drugs during pregnancy?
☐ Yes (describe below) ☐ No ☐ Unknown

c. Were there any unusual issues related to the mother's labor and delivery?
☐ Yes (describe below) ☐ No ☐ Unknown

Supporting Information: Provide additional information on the customer's social/developmental history, including significant events in prenatal/birth/early childhood stages, enduring physical/medical conditions, and pervasive developmental or cognitive difficulties.

22. MEDICAL HISTORY

How many times has the customer been to the Emergency Room in the past 12 months?
☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4+ times

What was the reason for the ER visit(s)?

Has the customer ever been psychiatrically hospitalized?
☐ No ☐ Yes (*If **YES**, please describe below. Attach additional pages as needed.)*

Has the customer ever been medically hospitalized?
☐ No ☐ Yes (*If **YES**, please describe below. Attach additional pages as needed.)*

Supporting Information: Describe any other significant medical problems, treatments, hospitalizations, and outcomes not addressed above.