



ANNUAL PHYSICAL VERIFICATION FORM INSTRUCTIONS

Thank you for choosing to participate in the wellness program being offered through Cleveland Metropolitan School District. Your doctor will need to sign this VERIFICATION form so that you will receive credit.

- This form is for appointments between **11/1/2025-10/31/2026**
- Take the Annual Physical Verification Form to your Primary Care Physician for your annual visit by **10/31/2026**.
- Ask your Primary Care Physician to complete the form.
- Follow instructions at the bottom of the form to submit for credit.
- HealthWorks will record that you have completed your annual visit. Please allow 3 business days for the processing of your form.
- Your employer will receive confirmation that you have completed this portion of your wellness program

Thank you,
The IH21/HW Central Division Team

Please allow 3 business days for
processing of forms.
Questions? Call 513-751-1288



ANNUAL PHYSICAL VERIFICATION FORM

**Cleveland Metropolitan
School District**

**Form for appointments between 11/1/2025-10/31/2026
will be accepted if submitted NO LATER THAN 10/31/2026**

PERSONAL INFORMATION

Full Name :

Date Of Birth : ____/____/____

Home Address : _____

Phone Number : _____ E-Mail : _____

I am an employee

I am a spouse of an employee. Complete Policy Holder Info:

Policy Holder First Name: _____

Policy Holder Last Name: _____

Policy Holder Date of Birth: _____

PHYSICIAN VERIFICATION

This form is to verify an annual physical/well-check visit for a wellness program offered through the patient's employer.

The patient named above has completed a screening during the period of 11/1/2025-10/31/2026 that, at a minimum, included the following:

- Cholesterol Screening Yes
- Glucose Screening No
- Blood Pressure Screening No
- Body Mass Index (BMI)

I, _____ (Provider Name), conducted an annual physical/well-check office visit and received the paper Health Risk Assessment for the patient listed above. This visit was completed on _____ (Date).

Provider Signature : _____ Date : _____

To receive credit, upload this form to your personal dashboard:

- Login at myHealthWorksportal.com
- On your Wellness Checklist, click Annual Physical Verification
- Use "Click Here to Upload a Document for Review" to upload your form
- Choose a file and click ok (any file type permitted: PDF, screenshot, Word doc)
- A "Document Uploaded Successfully" box appears once uploaded
- Please allow 3 business days for processing of forms

Please allow 3 business days for processing of forms

Questions? Call 513-751-1288

Health Risk Assessment

creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.)	
In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume <i>each day</i> ?	Servings
Do you always fasten your seat belt when you are in the car? <input type="checkbox"/> Yes <input type="checkbox"/> No	
In the past 2 weeks, how often have you felt down, depressed, or hopeless? <input type="checkbox"/> Almost all of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Almost never	
In the past 2 weeks, how often have you felt little interest or pleasure in doing things? <input type="checkbox"/> Almost all of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Almost never	
Have your feelings caused you distress or interfered with your ability to get along socially with family or friends? <input type="checkbox"/> Yes <input type="checkbox"/> No	
In the past 2 weeks, how often have you felt nervous, anxious, or on edge? <input type="checkbox"/> Almost all of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Almost never	
In the past 2 weeks, how often were you not able to stop worrying or control you're worrying? <input type="checkbox"/> Almost all of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> Almost never	
How often is stress a problem for you in handling such things as:	
Your health: <input type="checkbox"/> Never or rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always	
Always Your finances: <input type="checkbox"/> Never or rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always	
Family/Social: <input type="checkbox"/> Never or rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always	
Work: <input type="checkbox"/> Never or rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Always	
How often do you get the social and emotional support you need: <input type="checkbox"/> Always <input type="checkbox"/> Usually <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never	
In the past 7 days, how much pain have you felt? <input type="checkbox"/> None <input type="checkbox"/> Some <input type="checkbox"/> A lot	
In general, would you say your health is <input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
In general, would you say your dental health is <input type="checkbox"/> Excellent <input type="checkbox"/> Very good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor	
On average, how many hours of sleep do you get per night?	Hours
Do you snore or has anyone told you that you snore? <input type="checkbox"/> Yes <input type="checkbox"/> No	
In the past 7 days, how often have you felt sleepy during the daytime? <input type="checkbox"/> Always <input type="checkbox"/> Usually <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely <input type="checkbox"/> Never	

*DO NOT RETURN HEALTH RISK ASSESSMENT TO HEALTHWORKS. ONLY RETURN PHYSICIAN CERTIFICATION FORM.

