

“STAYING HEALTHY” ASSESSMENT
Adults, 18 years of age and older

Patient Stamp	
Patient Number _____	Plan Name/Number _____
<i>If patient stamp not used, write in Patient and Plan Name/Number</i>	

Patient's name (first, last)	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Today's date	For Clinical Use Assistance needed: Reading: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No
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You and your health care team can work together towards better health. Please answer these questions as best you can. You may check (✓) “Skip” if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your medical record.

Sample Question and Answer: Do you play sports?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	Interventions Code/Date/Initials
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Do You:				
1. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	<input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> Skip	
2. See the dentist at least once a year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
3. Drink milk or eat yogurt or cheese at least 3 times each day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
4. Eat fruits and vegetables every day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
5. Try to limit the amount of fried or fast foods that you eat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
6. Exercise or do moderate physical activity such as walking or gardening 5 days a week?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
7. Think you need to lose or gain weight?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
8. Often feel sad, down, or hopeless?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
9. Have friends or family members that smoke in your home?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
10. Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	

For Clinical Use

Intervention Codes: C: Counseling EM: Educational Materials R: Referral F: Follow-up Needed SPN: See Progress Notes

Your answers to questions about alcohol and drug use cannot be released to others without your special written permission.

For Clinical Use

Interventions
Code/Date/Initials

Do You:

- 11. Smoke cigarettes or cigars or use any other kinds of tobacco? No Yes Skip
- 12. Use any drugs or medicines to go to sleep, relax, calm down, feel better, or lose weight? No Yes Skip
- 13. Often have more than 2 drinks containing alcohol in one day? No Yes Skip
- 14. Think you or your partner could be pregnant? No Yes Skip
- 15. Think you or your partner could have a sexually transmitted disease? No Yes Skip

Have You:

- 16. Or your partner(s) had sex without using birth control in the last year? No Yes Skip
- 17. Or your partner(s) had sex with other people in the past year? No Yes Skip
- 18. Or your partner(s) had sex without a condom in the past year? No Yes Skip
- 19. Ever been forced or pressured to have sex? No Yes Skip
- 20. Ever been hit, slapped, kicked, or physically hurt by someone? No Yes Skip
- 21. Do you have other questions or concerns about your health? No Yes Skip

(Please identify) _____

For Clinical Use

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Privacy Statement

The Information Practices Act of 1977 (California Civil Code 1798) and the Federal Privacy Act (5 USC 552a, Subdivision (E)(3)) require this notice to be provided when collecting personal information from individuals. The information on this form is requested by your health care provider, health plan, and the Department of Health Services for purposes of providing health education services. Furnishing the information requested on this form is optional for the patient. Failure to provide the information requested will not result in any negative consequence for the patient. Information collected on this form is to be maintained in the patient's medical record, and is subject to the same medical and legal protection as other information maintained in the patient's medical record. State law and regulation including reporting requirements and protection of patient confidentiality applies to all information identified on this form. Within the constraints of these laws and regulations, certain information collected on this form may be transferred to state and local governmental and regulating agencies, contracted health plans, and health care providers.