

State of California - Health and Human Services Agency

Department of Health Services

"STAYING HEALTHY" ASSESSMENT **Adults, 18 years of age and older**

Patient Stamp

Patient Number

Plan Name/Number

If patient stamp not used, write in Patient and Plan Name/Number

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.

Annual Review
Date/Initials

Sample Question and Answer: Do you play sports?

Yes

No

Skip

Interventions
Code/Date/Initials

Do You:

- | | | | |
|--|-----|-----|------|
| 1. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)? | No | Yes | Skip |
| 2. See the dentist at least once a year? | Yes | No | Skip |
| 3. Drink milk or eat yogurt or cheese at least 3 times each day? | Yes | No | Skip |
| 4. Eat at least 5 servings of fruits or vegetables each day? | Yes | No | Skip |
| 5. Try to limit the amount of fried or fast foods that you eat? | Yes | No | Skip |
| 6. Exercise or do moderate physical activity such as walking or gardening 5 days a week? | Yes | No | Skip |
| 7. Think you need to lose or gain weight? | No | Yes | Skip |
| 8. Often feel sad, down, or hopeless? | No | Yes | Skip |
| 9. Have friends or family members that smoke in your home? | No | Yes | Skip |
| 10. Often spend time outdoors without sunscreen or other protection such as a hat or shirt? | No | Yes | Skip |

For Clinical Use

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

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

		No	Yes	Skip	Interventions Code/Date/Initials
11	Do you: Smoke cigarettes or cigars or use any other kinds of tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12	Use any drugs or medicines to go to sleep, relax, calm down, feel better, or lose weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13	Often have more than 2 drinks containing alcohol in one day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14	Think you or your partner could be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15	Think you or your partner could have a sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Have you:					
16	Or your partner(s) had sex without using birth control in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17	Or your partner(s) had sex with other people in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18	Or your partner(s) had sex without a condom in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19	Ever been forced or pressured to have sex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20	Ever been hit, slapped, kicked, or physically hurt by someone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21	Do you have other questions or concerns about your health? (Please identify) _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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

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 regulatory agencies, contracted health plans, and health care providers.