"STAYING HEALTHY ASSESSMENT"
ADULTS, 18 Years of age and older

You and Your health care team can work together towards better health. Please answer these questions as best you can. You may talk with your provider about any questions. Your answer will be protected as part of your medical record.

Do You:

1.Receive health care from anyone besides a medical doctor(such as an acupuncturist, curandero, or other healer)? Yes No 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 least 5 servings of fruits or vegetables each day ? Yes No Skip

5. Try to limit the amount of fried or fast foods ? 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 ? Yes NO Skip

8. Often feel sad, down, or hopeless? Yes No Skip

9. Have friends or family members that smoke in your home? Yes No Skip

10.Often spend time outdoors without sunscreen or other protection such as a hat or shirt? Yes No Skip

For Clinical Use
Intervention Codes: C:Counseling EM:Educational Materials R:Referral F: Follow-up SPN: See Progress Note

For clinical use

Assistance needed:
Reading: Yes No
Interpreter: Yes No

Interventions Code/Date/Initials

1.________

2.________

3.________

4.________

5.________

6.________

7.________

8.________

9.________

10.________

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

Do You:

11.Smoke cigarettes or cigars or use any other kinds of tobacco? Yes No Skip

12.Use any drugs or medicines to go to sleep, relax, calm down, feel better , or loss weight? Yes No Skip

13.Often have more than 2 drinks containing alcohol in one day? Yes No Skip

14.Think you or your partner could be pregnant? Yes No Skip

15.Think you or your partner could have a sexually transmitted disease? Yes No Skip

Have you :

16.Or your partner (s) had sex without using birth control in the last year ? Yes No Skip

17.Or you partner (s) had sex with other people in the past Year? Yes No Skip

18.Or your partner(s) had sex without a condom in the past Year? Yes No Skip

19. Ever been forced or pressured to have sex? Yes No Skip

20.Ever been hit, slapped, kicked, or physically hurt by someone? Yes No Skip

21. Do you have other questions or concerns about your health? Yes No Skip

(Please identify)____

____

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

---

For Clinical Us

Interventions Code/Date/Initials

11.__________

12.__________

13.__________

14.__________

15.__________

16.__________

17.__________

18.__________

19.__________

20.__________

21.__________