"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 ❒ Male ❒ Female	Today's date	***For Clinical Use*** **Assistance needed:** **Reading:** ❒ Yes ❒ No **Interpreter:** ❒ Yes ❒ No

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

					Interventions Code/Date/Initials
	Sample Question and Answer: Do you play sports?	✔ Yes	No	Skip	
	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 fruits and vegetables every 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: 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?** (Please identify) _____ _____ _____ _____	No	Yes	Skip	

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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.