State of California - Health and Human Services Agency | Department of Health Care Services

Staying Healthy Assessment

Adult

Today's Date

First Name | **Middle Name / MI** | **Last Name**

Date of Birth | **Sex**

Person Completing Form (if patient needs help)

- Family Member
- Friend
- Other

Other

Need help with form?

- Yes
- No

Need Interpreter?

- Yes
- No

Please answer all the questions on this form as best you can. Check "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

1. Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?

- Yes
- No
- Skip

2. Do you eat fruits and vegetables every day?

- Yes
- No
- Skip

3. Do you limit the amount of fried food or fast food that you eat?

- Yes
- No
- Skip

4. Are you easily able to get enough healthy food?

- Yes
- No
- Skip

5. Do you drink a soda, juice drink, sports or energy drink most days of the week?

- Yes
- No
- Skip

6. Do you often eat too much or too little food?

- Yes
- No
- Skip

7. Are you concerned about your weight?

- Yes
- No
- Skip

8. Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day?

- Yes
- No
- Skip

9. Do you feel safe where you live?

- Yes
- No
- Skip

10. Have you had any car accidents lately?

- Yes
- No
- Skip

11. Have you been hit, slapped, kicked, or physically hurt by someone in the last year?

- Yes
- No
- Skip

12. Do you always wear a seat belt when driving or riding in a car?

- Yes
- No
- Skip

13. Do you keep a gun in your house or place where you live?

- Yes
- No
- Skip

14. Do you brush and floss your teeth daily?

- Yes
- No
- Skip

15. Do you often feel sad, hopeless, angry, or worried?

- Yes
- No
- Skip

16. Do you often have trouble sleeping?

- Yes
- No
- Skip

17. Do you smoke or chew tobacco?

- Yes
- No
- Skip

18. Do friends or family members smoke in your house or place where you live?

- Yes
- No
- Skip

19. In the past year, have you had: (men) 5 or more alcohol drinks in one day? (women) 4 or more alcohol drinks in one day?

- Yes
- No
- Skip

20. Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?

- Yes
- No
- Skip

21. Do you think you or your partner could be pregnant?

- Yes
- No
- Skip

22. Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?

- Yes
- No
- Skip

23. Have you or your partner(s) had sex without using birth control in the past year?

- Yes
- No
- Skip

24. Have you or your partner(s) had sex with other people in the past year?

- Yes
- No
- Skip

25. Have you or your partner(s) had sex without a condom in the past year?

- Yes
- No
- Skip

26. Have you ever been forced or pressured to have sex?

- Yes
- No
- Skip

27. Do you have other questions or concerns about your health?

- Yes
- No
- Skip

If yes, please describe

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