

**“STAYING HEALTHY” ASSESSMENT
Adolescents, 12–17 years of age**

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
Name of person completing form (if other than patient)	Relationship <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other			Assistance needed: Reading: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> 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.

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. Live at home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
2. Go to school?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
3. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
4. See the dentist at least once a year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
5. 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	
6. Eat at least 5 servings of fruits or vegetables each day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
7. 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	
8. Exercise or play an active sport 5 days a week?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
9. Think you need to lose or gain weight?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
10. Often feel sad, down, or hopeless?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
11. Always wear a seat belt when riding in a car?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
12. Always wear a helmet when riding a bike or skateboard?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
13. Spend time in a home where a gun is kept?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
14. Spend time in a home with anyone who smokes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
15. 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	

<i>For Clinical Use</i>				
Intervention Codes: C: Counseling EM: Educational Materials R: Referral F: Follow-up Needed SPN: See Progress Notes				

Your answers to questions about sex and family planning cannot be shared with anyone, including your parents, without your special written permission.		For Clinical Use		
		Interventions	Code	Date/Initials
Do you ever:				
16.	Smoke cigarettes or cigars or chew tobacco?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
17.	Drink alcohol such as beer, wine, wine coolers, or liquor?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
18.	Drive a car after drinking or ride in a car driven by someone who has been drinking?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
19.	Use drugs such as marijuana, cocaine, crack, crank, or ecstasy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
20.	Have you ever had sex? <i>If "yes," continue to next question. If "no," go to question 26</i>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
21.	Do you think you or your partner could be pregnant?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
22.	Have you had sex without using birth control in the last year?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
23.	Do you think you or your partner could have a sexually transmitted disease?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
24.	Have you or your partner(s) had sex with any other people in the past year?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
25.	Did you or your partner use a condom the last time you had sex?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip
Have you:				
26.	Ever been forced or pressured to have sex?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
27.	Ever been hit, slapped, kicked, or physically hurt by someone?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
28.	Ever carried a gun, knife, club, or other weapon?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
29.	Do you have other questions or concerns about your health? (Please identify) _____ _____ _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip

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.