# Staying Healthy Assessment

## Adult

Clear Form

| Patient's Name (first & last) | Date of Birth | ☐ Female ☐ Male | Today's Date |
|---|---|---|---|
| | | | |

Person Completing Form *(if patient needs help)* ☐ Family Member ☐ Friend ☐ Other (*Specify*) _____ Need help with form? ☐ Yes ☐ No

*Please answer all the questions on this form as best you can. Circle "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.*

Need Interpreter? ☐ Yes ☐ No

| | | | | | *Clinic Use Only:* |
|---|---|---|---|---|---|
| 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 | Nutrition |
| 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? | ○ No | ○ Yes | ○ Skip | |
| 6 | Do you often eat too much or too little food? | ○ No | ○ Yes | ○ Skip | |
| 7 | Are you concerned about your weight? | ○ No | ○ Yes | ○ Skip | |
| 8 | Do you exercise or spend time doing activities, such as walking, gardening, swimming for ½ hour a day? | ○ Yes | ○ No | ○ Skip | Physical Activity |
| 9 | Do you feel safe where you live? | ○ Yes | ○ No | ○ Skip | Safety |
| 10 | Have you had any car accidents lately? | ○ No | ○ Yes | ○ Skip | |
| 11 | Have you been hit, slapped, kicked, or physically hurt by someone in the last year? | ○ No | ○ Yes | ○ 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? | ○ No | ○ Yes | ○ Skip | |
| 14 | Do you brush and floss your teeth daily? | ○ Yes | ○ No | ○ Skip | Dental Health |
| 15 | Do you often feel sad, hopeless, angry, or worried? | ○ No | ○ Yes | ○ Skip | Mental Health |
| 16 | Do you often have trouble sleeping? | ○ No | ○ Yes | ○ Skip | |
| 17 | Do you smoke or chew tobacco? | ○ No | ○ Yes | ○ Skip | Alcohol, Tobacco, Drug Use |
| 18 | Do friends or family members smoke in your house or place where you live? | ○ No | ○ Yes | ○ Skip | |

| | | | | | |
|---|---|---|---|---|---|
| 19 | In the past year, have you had:<br>☐ **(men)** 5 or more alcohol drinks in one day?<br>☐ **(women)** 4 or more alcohol drinks in one day? | ○ No | ○ Yes | ○ Skip | |
| 20 | Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight? | ○ No | ○ Yes | ○ Skip | |
| 21 | Do you think you or your partner could be pregnant? | ○ No | ○ Yes | ○ Skip | Sexual Issues |
| 22 | Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.? | ○ No | ○ Yes | ○ Skip | |
| 23 | Have you or your partner(s) had sex without using birth control in the past year? | ○ No | ○ Yes | ○ Skip | |
| 24 | Have you or your partner(s) had sex with other people in the past year? | ○ No | ○ Yes | ○ Skip | |
| 25 | Have you or your partner(s) had sex without a condom in the past year? | ○ No | ○ Yes | ○ Skip | |
| 26 | Have you ever been forced or pressured to have sex? | ○ No | ○ Yes | ○ Skip | |
| 27 | Do you have other questions or concerns about your health? | ○ No | ○ Yes | ○ Skip | Other Questions |

*If yes, please describe:*

| ***Clinic Use Only*** | Counseled | Referred | Anticipatory Guidance | Follow-up Ordered |
|---|---|---|---|---|
| ☐ Nutrition | ☐ | ☐ | ☐ | ☐ |
| ☐ Physical activity | ☐ | ☐ | ☐ | ☐ |
| ☐ Safety | ☐ | ☐ | ☐ | ☐ |
| ☐ Dental Health | ☐ | ☐ | ☐ | ☐ |
| ☐ Mental Health | ☐ | ☐ | ☐ | ☐ |
| ☐ Alcohol, Tobacco, Drug Use | ☐ | ☐ | ☐ | ☐ |
| ☐ Sexual Issues | ☐ | ☐ | ☐ | ☐ |

Comments:

☐ **Patient Declined the SHA**

PCP's Signature: Print Name: Date:

**SHA ANNUAL REVIEW**

PCP's Signature: Print Name: Date:

PCP's Signature: Print Name: Date:

PCP's Signature: Print Name: Date:

PCP's Signature: Print Name: Date:

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# Social Needs Screening Tool

## HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?[1]
   - ☐ Yes
   - ☐ No

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[2]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

## FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

## TRANSPORTATION

5. Do you put off or neglect going to the doctor because of distance or transportation?[1]
   - ☐ Yes
   - ☐ No

## UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[4]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

## CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?[5]
   - ☐ Yes
   - ☐ No

## EMPLOYMENT

8. Do you have a job?[6]
   - ☐ Yes
   - ☐ No

## EDUCATION

9. Do you have a high school degree?[6]
   - ☐ Yes
   - ☐ No

## FINANCES

10. How often does this describe you? I don't have enough money to pay my bills:[7]
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

## PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

12. How often does anyone, including family, insult or talk down to you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

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13. How often does anyone, including family, threaten you with harm?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

14. How often does anyone, including family, scream or curse at you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

## ASSISTANCE

15. Would you like help with any of these needs?
    - ☐ Yes
    - ☐ No

### SCORING INSTRUCTIONS:

**For the housing, food, transportation, utilities, child care, employment, education, and finances questions: Underlined answers indicate a positive response for a social need for that category.**

**For the personal safety questions: A value greater than 10, when the numerical values are summed for answers to these questions, indicates a positive response for a social need for personal safety.**

**Sum of questions 11–14:**
**Greater than 10 equals positive screen for personal safety.**

## REFERENCES


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3. Hager ER, Quigg AM, Black MM, et al. Development and validity of a 2-item screen to identify families at risk for food insecurity. *Pediatrics.* 2010;126(1):e26-e32.
4. Cook JT, Frank DA, Casey PH, et al. A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. *Pediatrics.* 2008;122(4):e867-e875.
5. Children's HealthWatch. Final: 2013 Children's Healthwatch survey. http://www.childrenshealthwatch.org/methods/our-survey/. Accessed October 3, 2018.
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7. Aldana SG, Liljenquist W. Validity and reliability of a financial strain survey. *J Financ Couns Plan.* 1998;9(2):11-19.
8. Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. HITS: a short domestic violence screening tool for use in a family practice setting. *Fam Med.* 1998;30(7):508-512.



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Cardin HealthCare
For the Best Health

# AUDIT-C AND DAST-10
# ALCOHOL AND DRUG USE SCREENING

Cardin HealthCare | 2880 Atlantic Ave, Suite 110 & 210, Long Beach, CA 90806
Phone (562) 424-4404 | Fax (562) 424-4770

CONFIDENTIAL

| Patient Name (first, last) * | Date of Birth (MM/DD/YYYY) | Date |
|---|---|---|
| | | |

## AUDIT-C: ALCOHOL USE

**1. How often do you have a drink containing alcohol?**

○ Never ○ Monthly or less ○ 2 to 4 times a month ○ 2 to 3 times a week
○ 4 or more times a week

**2. How many standard drinks containing alcohol do you have on a typical day?**

○ 1 or 2 ○ 3 or 4 ○ 5 or 6 ○ 7 to 9 ○ 10 or more

**3. How often do you have six or more drinks on one occasion?**

○ Never ○ Less than monthly ○ Monthly ○ Weekly ○ Daily or almost daily

## DAST-10: DRUG USE QUESTIONS

These questions are about drug use in the past 12 months. Do not include alcohol or tobacco.

| | | | |
|---|---|---|---|
| **1.** | Have you used drugs other than those required for medical reasons? | ○ Yes | ○ No |
| **2.** | Do you abuse more than one drug at a time? | ○ Yes | ○ No |
| **3.** | Are you unable to stop using drugs when you want to? | ○ Yes | ○ No |
| **4.** | Have you ever had blackouts or flashbacks as a result of drug use? | ○ Yes | ○ No |
| **5.** | Do you ever feel bad or guilty about your drug use? | ○ Yes | ○ No |
| **6.** | Does your spouse (or parents) ever complain about your involvement with drugs? | ○ Yes | ○ No |
| **7.** | Have you neglected your family because of your use of drugs? | ○ Yes | ○ No |
| **8.** | Have you engaged in illegal activities in order to obtain drugs? | ○ Yes | ○ No |
| **9.** | Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | ○ Yes | ○ No |
| **10.** | Have you ever had medical problems as a result of your drug use (for example: memory loss, hepatitis, convulsions, bleeding)? | ○ Yes | ○ No |

## OFFICE USE ONLY

| AUDIT-C Score (0 to 12) | DAST-10 Score (0 to 10) | Provider |
|---|---|---|
| | | |

### DAST-10 Suggested Action:

○ 0: No problems reported, none at this time ○ 1 to 2: Low level, monitor and reassess in 1 year
○ 3 to 5: Moderate level, further investigation ○ 6 to 8: Substantial level, intensive assessment
○ 9 to 10: Severe level, intensive assessment

# Hurt, Insulted, Threatened with Harm and Screamed (HITS)
# Domestic Violence Screening Tool

*Please read each of the following activities and place a check mark in the box that best indicates the frequency with which your partner acts in the way depicted.*

Date: _____ Name: _____

**Please Complete for the Past 12 Months Only**

Age: _____

Sex: Male ◯ Female ◯

Ethnicity: Caucasian ☐ Hispanic ☐ African American ☐ Asian ☐ Indian ☐

| How often does your partner? | Never | Rarely | Sometimes | Fairly Often | Frequently |
|---|---|---|---|---|---|
| 1. Physically hurt you | ◯ | ◯ | ◯ | ◯ | ◯ |
| 2. Insult or talk down to you | ◯ | ◯ | ◯ | ◯ | ◯ |
| 3. Threaten you with harm | ◯ | ◯ | ◯ | ◯ | ◯ |
| 4. Scream or curse at you | ◯ | ◯ | ◯ | ◯ | ◯ |
| | 1 | 2 | 3 | 4 | 5 |
| Total Score: | | | | | |

Each item is scored from 1-5. Range between 4-20. A score greater than 10 signify that you are at risk of domestic violence abuse, and should seek counseling or help from a domestic violence resource center such as the following:

**Help in Los Angeles County (free, confidential, 24 hours a day):**

LA County Domestic Violence Hotline: 1-800-978-3600

National Domestic Violence Hotline: 1-800-799-SAFE (7233), or text START to 88788

If you are in danger right now, call 911.

For more information, call 1.800.4BAYLOR or visit us online at BaylorHealth.com/DallasTrauma.

BAYLOR University Medical Center at Dallas

Level 1 Trauma Center

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# California Adult Tuberculosis Risk Assessment (>18 years old)

Despite being preventable, tuberculosis (TB) disease continues to cause significant suffering and death in the state of California. Even with modern treatments, more than 1 in 6 Californians with TB die (bit.ly/cdc_tbca_data). TB is also a health disparity in California, with a disproportionate impact on people born outside the United States. **Identifying and treating persons with latent TB infection (LTBI) is the most promising tool to prevent TB disease.**

- **Use this tool to identify asymptomatic adults for LTBI testing.**
- **Do not treat for LTBI until active TB disease has been excluded.**
- **A negative tuberculin skin test or interferon gamma release assay does not rule out active TB disease.**

If a patient has symptoms of TB disease, including cough (for more than 2 weeks), fevers, night sweats, unexplained weight loss, or an abnormal chest x-ray consistent with TB disease, they should undergo further workup. **Contact your local TB control program** (https://www.ctca.org/locations.html) **if there is suspicion for active TB disease.**

## LTBI testing is recommended if any of the boxes below are checked.

Only repeat TB testing if there is a new risk factor since last screening

☐ **Birth, travel, or residence** for at least 1 month, or frequent border crossing in a country with an elevated TB rate*

Interferon Gamma Release Assay (IGRA) is preferred over Tuberculin Skin Test (TST), especially for non-U.S.-born persons

☐ **Immunosuppression**, current or planned

HIV infection, organ transplant recipient, treated with biologic agents including TNF-alpha antagonist (e.g., infliximab, adalimumab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact** to someone with infectious TB disease during lifetime

☐ **Homelessness or incarceration,** current or past

Persons experiencing homelessness or residing in high-risk congregate settings including homeless shelter or correctional facility during lifetime

## Treat for LTBI if LTBI test result is positive and active TB disease is excluded.

☐ **None;** no TB testing is indicated at this time.

**Provider:** _____

**Assessment Date:** _____

**Patient Name:** _____

**Date of Birth:** _____

*(Place sticker here if applicable)*

**For more information about using this tool and for the most current version, go the TB Risk Assessment page** (cdph.ca.gov/tbriskassessment).

# Patient Health Questionnaire (PHQ-9)

Name: Date:

| Over the last 2 weeks, how often have you been bothered by any of the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 |
| 2. Feeling down, depressed, or hopeless | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 |
| 4. Feeling tired or having little energy | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 |
| 5. Poor appetite or overeating | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 |
| 6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | ◯ 0 | ◯ 1 | ◯ 2 | ◯ 3 |

For office coding: Total Score = + + 

Total Score

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

◯ Not difficult at all ◯ Somewhat difficult ◯ Very difficult ◯ Extremely difficult

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For the Best Health

# ADVANCE DIRECTIVE, PRIVACY AND CONSENT FOR TREATMENT

Cardin HealthCare | 2880 Atlantic Ave, Suite 110 & 210, Long Beach, CA 90806
Phone (562) 424-4404 | Fax (562) 424-4770

**PLEASE READ AND SIGN**

| Patient Name (first, last) * | Date of Birth (MM/DD/YYYY) * |
|---|---|
| | |

## ADVANCE DIRECTIVE

☐ I have an advance directive and will provide a copy.

☐ I have received information and instructions about advance directives.

☐ I decline advance directive information at this time.

I understand that I may update my advance directive at any time and provide a copy to Cardin HealthCare for my medical record.

## PRIVACY PRACTICES (HIPAA)

I, the patient named above, acknowledge that I have received and reviewed a copy of the Notice of Privacy Practices from Cardin HealthCare, Inc. I understand that this notice explains how my health information may be used and disclosed, and outlines my rights under HIPAA.

## GENERAL CONSENT FOR TREATMENT

I, the patient named above, hereby request and consent to medical evaluation, diagnostic procedures (including X-rays and lab work), and treatment as deemed necessary and advisable by the professional staff of Cardin HealthCare, Inc. I understand that this consent applies to routine healthcare services and does not include procedures that require a separate, specific consent form.

| Patient / Guardian Signature * | Date (MM/DD/YYYY) * |
|---|---|
| | |

☐ By checking this box and typing my first and last name above, I acknowledge that this will serve as my legal signature on this form.

| If signed by someone other than the patient: name and relationship |
|---|
| |