STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY GRAY DAVIS, Governor

DEPARTMENT OF HEALTH SERVICES
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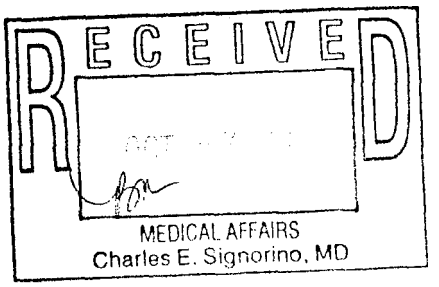
September 21, 1999

MMCD Policy Letter 99-07

TO:
- [X] Two-Plan Model Plans
- [X] Geographic Managed Care Plans
- [X] County Organized Health Systems Plans
- [ ] Prepaid Health Plans
- [ ] Primary Care Case Management Plans



SUBJECT: INDIVIDUAL HEALTH EDUCATION BEHAVIORAL ASSESSMENT

PURPOSE

The purpose of this policy letter is to clarify the contract responsibilities of Medi-Cal Managed Care Plans (hereafter referred to as the Plans) in conducting the Individual Health Education Behavioral Assessment. (Two-Plan Model Contract Section 6.7.7.3 and Geographic Managed Care Contract Section 7.4.) It is recommended that County Organized Health Systems (COHS) implement this policy letter as well.

BACKGROUND

Despite overall health improvements for the general population, and increasing emphasis on health promoting behaviors and preventive health, the Medi-Cal population continues to be burdened by preventable illness, injury and disability, and is at high risk for almost all major disease categories. Health benefits can be realized by placing increased priority on behaviors that promote optimum health and reduce risk for disease, injury and disability. In recognition of the importance of health education interventions in changing and promoting health behaviors, Plans are required to administer the Individual Health Education Behavioral Assessment to plan members within 120 days of enrollment.

At the request of Plan representatives, the Department of Health Services (DHS) convened the Health Education Assessment Tool (HEAT) Work Group to develop a standardized assessment tool for adoption by DHS. The "Staying Healthy" Assessment is the product of this collaboration, and the standardized tools that have been adopted by DHS for use by the Plans and providers of primary care services in the Plans' network.

GOALS

- To identify high-risk behaviors of individual plan members.
- To assist providers in prioritizing individual health education needs of their assigned patients related to lifestyle, behavior, environment, and cultural linguistic background.
- To assist providers in initiating and documenting focused health education interventions, referrals and follow-up.

POLICY

I. Individual Health Education Behavioral Assessment

The Plans must ensure that all new members complete the Individual Health Education Behavioral Assessment within 120 days of the effective date of enrollment as part of the initial health assessment; and that all existing members complete the Individual Health Education Behavioral Assessment at their next non-acute care visit, but no later than their next scheduled health screening exam. Members must be informed of their right to refuse to answer any assessment question or to complete the assessment. If a plan member declines to complete the assessment, the refusal must be documented in the medical record.

The Plans are strongly encouraged to promote use of the "Staying Healthy" Assessment by primary care providers to meet this contract requirement. If a Plan wishes to use an assessment tool other than the "Staying Healthy" Assessment for its entire provider network, these tools must be submitted to the DHS, Office of Clinical Standards and Quality, for approval prior to implementation. Alternative assessment tools must be accompanied by a description of their development process, including pilot testing, translation and field-testing.

DHS will review alternative assessment tools based on the following criteria:

- Designed to perform the same screening, assessment and documentation functions as the "Staying Healthy" Assessment.
- At a minimum, covers all the same content and specific risk factors as the "Staying Healthy" Assessment.
- Has undergone a development process equivalent to the "Staying Healthy" Assessment, including pilot testing with members and providers, translation, and field testing in the DHS threshold languages.

The Plan must ensure that assessment tools used by its sub-contracting medical groups, IPAs or individual primary care providers are either the same as or equivalent to the "Staying Healthy" Assessment tools based on the above criteria. Alternative tools used by contracting

providers or provider groups must be approved by the Plan, but need not be individually approved by DHS.

II. Effective Date of Enrollment

The effective date of enrollment is the first day of the month following notification by the Medi-Cal Eligibility Data System tape that a member is eligible to receive services from the Plan for which capitation will be paid, and the member is not on "hold" status.

III. Administration and Review of the Individual Health Education Behavioral Assessment

The primary care provider must:

1. Administer the assessment tool to the member within 120 days of enrollment.
2. Review the completed assessment tool with the member during an office visit.
3. Review the assessment tool and risk reduction plan at least annually with members who present for a scheduled visit.
4. Re-administer the assessment tool at the appropriate age-intervals utilized by the "Staying Healthy" Assessment (0-3 years, 4-8 years, 9-11 years, 12-17 years, and 18 years and older). This should occur at the patient's first scheduled health screening exam upon changing into the next age group.
5. Assure documentation, at initial and subsequent visits, of health education interventions on the assessment tool, including risk factors addressed, intervention codes, date and primary care provider's signature or initials. More extensive documentation in the progress notes is encouraged.
6. Include the completed assessment tool with the medical history and problem list as a permanent part of the member's medical record.
7. Provide assistance to members in completing the assessment tool, if needed.

The Plans must assist primary care providers in the development and delivery of culturally and linguistically appropriate health education interventions and assure provisions for low-literate, illiterate, and visually impaired members.

IV. Provider Training

The Plans must develop and implement relevant provider training programs to assure appropriate implementation of the Individual Health Education Behavioral Assessment. At a minimum, provider training must include: a) the purpose of administering the Individual Health Education Behavioral Assessment tool; b) timelines for administration, review and re-administration of the tool; c) culturally and linguistically appropriate health education interventions; and d) plan-specific information regarding resources and referral.

Confidentiality

It is expected that the Individual Health Education Behavioral Assessment will be completed by parents/guardians for children and self-completed by adolescents and adults. The Plans are responsible to protect member confidentiality, especially as it relates to family planning, sexuality issues, and alcohol/drug use.

V. Distribution and Availability of the "Staying Healthy" Assessment

The Plans will receive camera-ready copies of the English and Spanish version of the "Staying Healthy" Assessment tools. The Plans will also receive camera-ready copies of the "Staying Healthy" Assessment tools in other threshold languages as they are made available by DHS. The Plans must assure that primary care providers have the means to obtain an adequate supply of legible "Staying Healthy" Assessment tools or alternative approved assessment tools. The Plans and/or providers may reproduce the "Staying Healthy" Assessment tools, or alternative approved tools on NCR or other types of paper, but are not allowed to make changes in text.

VI. Timeline

The Plans must begin implementation of the Individual Health Education Behavioral Assessment requirement upon release of this policy letter. By March 1, 2000, the Plans must ensure that primary care providers are using the English and Spanish versions of the "Staying Healthy" Assessment, or alternative approved tools that comply with DHS approval criteria. Finally, the Plans must implement the "Staying Healthy" Assessment in other threshold languages as they are adopted by DHS, and ensure that primary care providers begin implementation of these tools within three (3) months of their release by DHS. The Plans must implement alternative approved tools in other threshold languages according to the same timeline as that established for the "Staying Healthy" Assessment in those languages.

DISCUSSION

The Individual Health Education Behavioral Assessment will assist the primary care provider in identifying and tracking individual member health risks and behaviors, and providing targeted health education counseling interventions, referral, and follow-up. The assessment tools will become a permanent part of the medical record and may be referred to throughout the course of the patient's care. The primary care provider will be able to quickly review patient responses and prioritize risk categories. It is expected that primary care providers will ask appropriate follow-up assessment questions to identify patients health education needs and facilitate focused health education counseling addressing health behavior changes.

It is recommended that the Individual Health Education Behavioral Assessment for adolescents, age 12 to 17, be re-administered annually to address the changing risk status of this age group. For adults age 18 and older, it is recommended that the Individual Health Education Behavioral Assessment be re-administered every three to five years, and more frequently for young adults. The "Staying Healthy" Assessment has not been designed to address the specific needs of members over age 65; however, it may serve as a tool to initiate discussion of health promoting behaviors for this population as well.

The Individual Health Education Behavioral Assessment tool should be reviewed by the primary care provider in combination with the following relevant information:

- Medical history, conditions, problems, and concerns as well as medical/testing results.
- Social history, including patient's demographic data, personal circumstances, family composition, patient resources and social support.
- Local demographic and epidemiologic factors which influence risk status.

The Department of Health Services will proceed to translate, field test and produce the "Staying Healthy" Assessment in the other DHS threshold languages. The final translated "Staying Healthy" Assessment will be made available to the Plans in other languages at the earliest possible date. It is recommended that a copy of the English version of the "Staying Healthy" Assessment or alternative approved tool, accompany completed versions of the assessment tool in other languages in the medical record to facilitate review by primary care providers.

If you have any questions regarding this policy letter, please contact your contract manager.

Susanne M. Hughes
Acting Chief
Medi-Cal Managed Care Division

Attachment

Attachment I

"STAYING HEALTHY" ASSESSMENT
Children, 0–3 years of age

Patient Stamp

Patient Number _____ Plan Name/Number _____

If patient stamp not used, write in Patient and Plan Name/Number

Child's name (first, last)	Date of birth	Sex	Today's date
		☐ Male ☐ Female	
Your name	Relationship to child ☐ Parent ☐ Guardian ☐ Relative ☐ Friend ☐ Other		

For Clinical Use

Assistance needed:

Reading: ☐ Yes ☐ No

Interpreter: ☐ Yes ☐ No

You and your child's 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 child's medical record.

Annual Review Date/Initials

Sample Question and Answer: Does your child go to preschool?	✔ Yes	No	Skip	**Interventions Code/Date/Initials**
Does Your Home Have:				
1. A working smoke detector?	Yes	No	Skip	
2. Water that comes from the faucet hot enough to burn your child?	No	Yes	Skip	
3. Window guards and stair gates above the first floor?	Yes	No	Skip	
4. Cleaning supplies, medicines, and matches in a locked cabinet?	Yes	No	Skip	
5. Syrup of Ipecac (the medicine used to cause vomiting) and the Poison Control phone number for emergencies?	Yes	No	Skip	
Do You:				
6. Always put your child to sleep on his/her back, if younger than 12 months of age?	Yes	No	Skip	
7. Ever put your child to sleep with a bottle of juice, milk, or soda?	No	Yes	Skip	
8. Make sure your child's teeth are brushed every day?	Yes	No	Skip	
9. Always stay with your child when she/he is in the bathtub?	Yes	No	Skip	
10. Always put your child in a car seat and seat belt in the back seat of a car?	Yes	No	Skip	
11. Always walk around your car to check for children before backing out?	Yes	No	Skip	

For Clinical Use

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

					For Clinical Use Interventions Code/Date/Initials
	Does Your Child:				
12.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	No	Yes	Skip	
13.	Breastfeed?	No	Yes	Skip	
14.	Drink formula, milk, or eat yogurt at least 2 times each day?	Yes	No	Skip	
15.	Eat fruits and vegetables every day?	Yes	No	Skip	
16.	Eat foods that may cause choking such as nuts, popcorn, hotdogs, whole grapes, or hard candy?	No	Yes	Skip	
17.	Spend time at a house or apartment complex with a swimming pool or hot tub?	No	Yes	Skip	
18.	Spend time in a home where a gun is kept?	No	Yes	Skip	
19.	Spend time in a home with anyone who smokes?	No	Yes	Skip	
20.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	No	Yes	Skip	
21.	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
22.	**Do you have other questions or concerns about your child's health?** (Please identify) _____	No	Yes	Skip	

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

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.

"STAYING HEALTHY" ASSESSMENT
Children, 4–8 years of age

Patient Stamp

Patient Number _____ Plan Name/Number _____

If patient stamp not used, write in Patient and Plan Name/Number

Child's name (first, last)	Date of birth	Sex	Today's date
		☐ Male ☐ Female	
Your name	Relationship to child ☐ Parent ☐ Guardian ☐ Relative ☐ Friend ☐ Other		

You and your child's 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 child's medical record.

Sample Question and Answer: Does your child play sports? Yes ✔ | No | Skip

	Does Your Home Have:			
1.	A working smoke detector?	Yes	No	Skip
2.	Water that comes from the faucet hot enough to burn your child?	No	Yes	Skip
3.	Window guards above the first floor?	Yes	No	Skip
4.	Cleaning supplies, medicines, and matches in a locked cabinet?	Yes	No	Skip
5.	Syrup of Ipecac (the medicine used to cause vomiting) and the Poison Control phone number for emergencies?	Yes	No	Skip
	Does Your Child:			
6.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	No	Yes	Skip
7.	See the dentist at least once a year?	Yes	No	Skip
8.	Drink milk or eat yogurt or cheese at least 2 times each day?	Yes	No	Skip
9.	Eat at least 5 servings of fruits or vegetables each day?	Yes	No	Skip
10.	Eat only a limited amount of fried or fast foods?	Yes	No	Skip

For Clinical Use

Assistance needed:
Reading: ☐ Yes ☐ N
Interpreter: ☐ Yes ☐ N

Annual Review Date/Initials

Interventions Code/Date/Initials

For Clinical Use

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

					For Clinical Use Interventions Code/Date/Initials
	Does Your Child:				
11.	Play actively 5 days a week?	Yes	No	Skip	
12.	Need to lose or gain weight?	No	Yes	Skip	
13.	Ever play in the street or unsupervised in the front yard?	No	Yes	Skip	
14.	Always wear a seat belt when riding in a car?	Yes	No	Skip	
15.	Always wear a helmet when riding a bike or skateboard?	Yes	No	Skip	
16.	Spend time at a house or apartment complex with a swimming pool or hot tub?	No	Yes	Skip	
17.	Spend time in a home where a gun is kept?	No	Yes	Skip	
18.	Spend time in a home with anyone who smokes?	No	Yes	Skip	
19.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	No	Yes	Skip	
	Has Your Child:				
20.	Ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
21.	Had any problems at home or school?	No	Yes	Skip	
22.	**Do you have other questions or concerns about your child's health?**	No	Yes	Skip	
	(Please identify) _____				
	_____				
	_____				
	_____				

For Clinical Use

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

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"STAYING HEALTHY" ASSESSMENT
Pre-adolescents, 9–11 years of age

Patient Stamp

Patient Number _____ Plan Name/Number _____

If patient stamp not used, write in Patient and Plan Name/Number

Child's name (first, last)	Date of birth	Sex ☐ Male ☐ Female	Today's date
Your name	Relationship to child ☐ Parent ☐ Guardian ☐ Relative ☐ Friend ☐ Other		

For Clinical Use
Assistance needed:
Reading: ☐ Yes ☐ N
Interpreter: ☐ Yes ☐ N

You and your child's 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 child's medical record.

Annual Review Date/Initials

Sample Question and Answer: Does your child go to school?	Yes ✔	No	Skip

Interventions Code/Date/Initials

Does Your Child:

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 at least 5 servings of fruits or vegetables each day?	Yes	No	Skip	
5.	Eat only a limited amount of fried or fast foods?	Yes	No	Skip	
6.	Play actively 5 days a week?	Yes	No	Skip	
7.	Need to lose or gain weight?	No	Yes	Skip	
8.	Often feel sad or depressed?	No	Yes	Skip	
9.	Always wear a helmet when riding a bike or skateboard?	Yes	No	Skip	
10.	Always wear a seatbelt when riding in a car?	Yes	No	Skip	
11.	Spend time in a home where a gun is kept?	No	Yes	Skip	

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

					For Clinical Use Interventions Code/Date/Initials
	Does Your Child:				
12.	Spend time with any friends who carry a gun, knife, club, or other weapon?	No	Yes	Skip	
13.	Spend time in a home with anyone who smokes?	No	Yes	Skip	
14.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	No	Yes	Skip	
	Has Your Child:				
15.	Ever smoked cigarettes or chewed tobacco?	No	Yes	Skip	
16.	Ever had alcohol such as beer, wine, wine coolers, or liquor?	No	Yes	Skip	
17.	Ever smoked marijuana, sniffed glue, or used street drugs?	No	Yes	Skip	
18.	Had friends or family members who had a problem with drugs or alcohol?	No	Yes	Skip	
19.	Started dating or "going with" boyfriends/girlfriends?	No	Yes	Skip	
20.	Become sexually active?	No	Yes	Skip	
21.	Ever been molested or sexually abused?	No	Yes	Skip	
22.	Ever witnessed or been a victim of physical abuse or violence?	No	Yes	Skip	
23.	Had problems at home or school?	No	Yes	Skip	
24.	**Do you have other questions or concerns about your child's health?** (Please identify) _____ _____ _____	No	Yes	Skip	

For Clinical Use

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

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"STAYING HEALTHY" ASSESSMENT
Adolescents, 12–17 years of age

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
Name of person completing form (If other than patient)	Relationship ☐ Parent ☐ Guardian ☐ Relative ☐ Friend ☐ Other		

For Clinical Use
Assistance needed:
Reading: ☐ Yes ☐ N
Interpreter: ☐ Yes ☐ N

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

	Yes	No	Skip
Sample Question and Answer: Do you play sports?	✔		

Interventions Code/Date/Initials

Do You:

		Yes	No	Skip
1.	Live at home?	Yes	No	Skip
2.	Go to school?	Yes	No	Skip
3.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	No	Yes	Skip
4.	See the dentist at least once a year?	Yes	No	Skip
5.	Drink milk or eat yogurt or cheese at least 3 times each day?	Yes	No	Skip
6.	Eat at least 5 servings of fruits or vegetables each day?	Yes	No	Skip
7.	Try to limit the amount of fried or fast foods that you eat?	Yes	No	Skip
8.	Exercise or play an active sport 5 days a week?	Yes	No	Skip
9.	Think you need to lose or gain weight?	No	Yes	Skip
10.	Often feel sad, down, or hopeless?	No	Yes	Skip
11.	Always wear a seat belt when riding in a car?	Yes	No	Skip
12.	Always wear a helmet when riding a bike or skateboard?	Yes	No	Skip
13.	Spend time in a home where a gun is kept?	No	Yes	Skip
14.	Spend time in a home with anyone who smokes?	No	Yes	Skip
15.	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 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? No | Yes | Skip
17. Drink alcohol such as beer, wine, wine coolers, or liquor? No | Yes | Skip
18. Drive a car after drinking or ride in a car driven by someone who has been drinking? No | Yes | Skip
19. Use drugs such as marijuana, cocaine, crack, crank, or ecstasy? No | Yes | Skip
20. **Have you ever had sex?** No | Yes | Skip
If "yes," continue to next question. If "no," go to question 26.
21. Do you think you or your partner could be pregnant? No | Yes | Skip
22. Have you had sex without using birth control in the last year? No | Yes | Skip
23. Do you think you or your partner could have a sexually transmitted disease? No | Yes | Skip
24. Have you or your partner(s) had sex with any other people in the past year? No | Yes | Skip
25. Did you or your partner use a condom the last time you had sex? Yes | No | Skip

Have you:

26. Ever been forced or pressured to have sex? No | Yes | Skip
27. Ever been hit, slapped, kicked, or physically hurt by someone? No | Yes | Skip
28. Ever carried a gun, knife, club, or other weapon? No | Yes | Skip
29. **Do you have other questions or concerns about your health?** No | Yes | Skip

(Please identify) _____

_____

_____

For Clinical Use

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

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"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 ☐ N Interpreter: ☐ Yes ☐ N

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?	Yes ✓	No	Skip	Annual Review Date/Initials

	Do You:				Interventions Code/Date/Initials
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 at least 5 servings of fruits or vegetables each 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	

For Clinical Use

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

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.