Staying Healthy Assessment – Revised 6/2025

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 soda, juice, sport drinks or energy drinks 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 the place where you live?	No	Yes	Skip	
14	Do you brush and floss your teeth daily?	Yes	No	Skip	
15	Depression screen: Over the past 2 weeks how often have you been bothered by any of the following: Little or no interest or pleasure in doing things? **If answer is positive – use PHQ-9 tool for further screening**	Not at all	Several days	More than half the days	**If yes to either question complete PHQ-9 screen enter data into EHR - screening section**
16	Depression screen: Over the past 2 weeks how often have you been bothered by any of the following: Feeling down, depressed or hopeless? **If answer is positive – use PHQ-9 tool for further screening**	Not at all	Several days	More than half the days	

17a	In the past 12 months how often have you used tobacco products (cigarettes, e-cig, cigars, pipes, or smokeless tobacco)? ___ Daily or almost Daily ___ Weekly ___ Monthly ___ Less than Monthly ___ Never				**Alcohol, Tobacco, Drug Use ENTER IN EHR**
17b	Do friends or family members smoke in your house or the place where you live?	No	Yes	Skip	
18a	In the past 12 months, how often have you had 5 or more drinks containing alcohol in one day? ___ Daily ___ Weekly ___ Monthly ___ Less than Monthly ___ Never				
18b	In the past 12 months, how often have you had 4 or more drinks containing alcohol in one day? ___ Daily ___ Weekly ___ Monthly ___ Less than Monthly ___ Never				
19a	In the past 12 months, how often have you used any drugs including marijuana, cocaine or crack, heroin, methamphetamine, hallucinogens or ecstasy? ___ Daily ___ Weekly ___ Monthly ___ Less than monthly ___ Never				
19b	In the past 12 months, how often have you used prescription medication just for the feeling, more than prescribed or were not prescribed for you? (for example, OxyContin, Vicodin, Percocet) or Medication for anxiety or sleeping (Xanax, Ativan, Klonopin or Medication for ADHD (Adderall or Ritalin) ___ Daily ___ Weekly ___ Monthly ___ Less than monthly ___ Never				
	If answers are positive to questions 18a-19b additional evaluation must be done. Use NIDA-Modified ASSIST tool				Additional evaluation and treatment required
20	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
21	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
22a	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
22b	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
22c	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
23a	Have you ever been forced or pressure to have sex?	No	Yes	Skip	
23b	**Do you feel safe in your current relationship?**	Yes	No	Skip	
23c	**Is there a partner from a previous relationship who is making you feel unsafe?**	No	Yes	Skip	
24	Do you have other questions or concerns about your health?	No	Yes	Skip	

If yes, please describe:

Provider Signature _____ *Patient name* _____

PATIENT NAME _____ **DOB** _____

Adult Preventative Care

Test/Exam Name	Frequency	Date Completed
Comprehensive H&P Exam	First appointment	
Subsequent Risk Assessment	Annual Well Exam – Staying Healthy Risk Assessment	
Alcohol Use Disorder Screening	Annually Included in Staying Healthy Risk Assessment Questions	
Breast Cancer Screening	Every 2 years for females over the age of 40	**CARE GAPS**
Cervical Cancer Screening	Females 21 years and older every 3 years	**CARE GAPS**
Colorectal Cancer Screening	Adults 45 years and older	**CARE GAPS**
Depression Screening using PHQ2 and PHQ9	First PCP appointment and Annual well exam	**ENTER IN EHR**
Diabetic Screening	HGA1c measured annually for adults 35-70 years old who are overweight or obese	
Comprehensive Diabetic Care for all adults diagnosed with diabetes	Regular monitoring of blood glucose (HGA1c) and blood pressure, eye exams to detect retinopathy, and kidney function tests to screen for nephropathy. Diabetic foot exam at least once a year.	
Adult Drug Disorder Screening and Counseling	Annual well exam –Staying healthy Assessment form	
Dyslipidemia Screening or Statin Treatment	Annually for Adults 40 – 75 years old	
Folic Acid Supplementation (0.4mg -0.8 mg daily)	Women of childbearing age (under 50 yrs) who are capable of becoming pregnant should be offered Folic Acid supplementation	
Hepatitis B Screening	**Screen for risk annually. One time Hep B screening with a triple panel for all adults**	
Hepatitis C Screening	Screen for risks annually 18-79 years old and more frequently for those at risk. Lab test to screen for Hep C at least once	
HIV Screening	Screen for risk annually for all adults up to 65 years, Lab testing ordered to screen for HIV at least once	
Intimate Partner Violence Screening	Women of reproductive age - See Staying Healthy Assessment annually	
Lung Cancer Screening, counseling and intervention - Tobacco use	Annual Screening - Past and current history of tobacco use See Staying Healthy Assessment Form. Counseling and Intervention (smoking cessation information) for smokers	**Enter in EHR each visit**
Lung Cancer Screening for adults with past history of 20 pack per year smoking history	Low dose Computed tomography once	
Sexually Transmitted Infections Screening and counseling	Screen for risk at least annually – Staying Health Assessment. Lab testing for Chlamydia, Gonorrhea, Syphilis, Trichomonas and/or Herpes at risk – all sexually active women under 25 yrs and older women with multiple sex partners	
Skin Cancer Behavioral Counseling	Counseling on risk of skin cancer for all patients under 25 at least once annually.	
TB Screening	California Adult Tuberculosis Risk Assessment Tool completed by all adults on first visit and annually. TB testing is done if the patient is at risk.	
Adult Immunizations given to ACIP standards	All Adults: COVID 19, Influenza, Tdap/Td, Varicella, MMR Over 50 years: Zoster 65 + years: Pneumococcal	**CARE GAPS**
Vaccine Immunization Statements	VIS to include date vaccine given and VIS publication date – recorded with each vaccine documented in chart	