15. HEALTH EDUCATION

A. Health Education

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP maintains a health education system that provides programs, services, functions, and resources necessary to deliver health education, health promotion and patient education at no cost to its Members.[1,2~~,3~~]

PROCEDURES:

A. IEHP delegates the delivery of clinical health education services for Members to the Providers.[4] Providers are responsible for providing Member-specific clinical health education services to assigned Members with assistance from their IPA, as needed. Areas for education include:

1. Condition-specific health education as needed for diabetes, asthma, and hypertension;
2. Tobacco use prevention and cessation;
3. Family planning;
4. Tuberculosis;
5. Human immunodeficiency virus (HIV)/sexually transmitted infection (STI) prevention;
6. Dental care;
7. Diet, nutrition, and physical activity;
8. Perinatal health;
9. Age-specific anticipatory guidance;
10. Immunizations;
11. Substance use disorders; and
12. Injury prevention.

B. Providers are responsible for identifying the need for clinical health education services through the following mechanisms or interactions:

1. Initial Health Assessment/Staying Healthy Assessment - behavioral or clinical questions

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 8, Services for All Members

[2] ~~Department of Health Care Services (~~DHCS~~)~~ Policy Letter (PL) 02-04, "Health Education"

[3] ~~DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 8, Services for All Members~~

[4] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 8, Services for All Members~~Ibid.~~

and observed need;

2. Periodic Physical Examinations - behavioral or clinical questions and observed need;
3. Acute illness visits - observed need (e.g., STI counseling/information if treated for STI); and
4. Chronic illness visits - observed need (e.g., dietary/exercise counseling for hypertensive patients).

C. Providers must directly deliver clinical health education services to Members within their scope of practice. Activities can include:

1. Direct information provided by the Provider (e.g., recommendation of exercise regimen for obese Members);
2. Supplying brochures or other printed materials to the Member that are pertinent to the need (e.g., the IEHP Immunizations brochure for parents with children); and
3. Use of educational videotapes in the waiting room or counseling room.

D. Providers are responsible for referring Members for additional necessary health education services that are beyond their scope of practice. Referral options include:

1. Referral to IEHP Health Education Programs;
2. Referral to community-based organizations or services; and
3. Referral to the IPA for medically necessary nutrition education such as Registered Dietitian services. See Policy 14D, "Pre-service Referral Authorization Process."

E. IPAs are responsible for assisting their Providers in the delivery of health education services including:

1. Arranging for medically necessary health education services upon referral from the Provider;
2. Coordinating and/or referring Members to community-based organizations that provide free or low-cost health education services, utilizing community referral resources such as 2-1-1; and
3. Providing health education materials including brochures, other written materials and/or videos to the Provider or the Member, including brochures available through IEHP.

F. IEHP provides health education services to Members and Providers through the following mechanisms:

1. Provision of brochures directly to Provider offices on topics including, but not limited to, antibiotic use, asthma, immunizations, and diabetes;
2. Information on community referral resources (e.g. connectie.org and 2-1-1) that list relevant resources in the community;
3. Provision of brochures to Members on topics including, but not limited to, Benefits of

Joining IEHP, Fever in Children, Parenting, and Contraception;

4. Direct delivery of Health Education Programs to Members to include self-management tools and anticipatory guidance on the following topics:
   a. Health and Wellness:
      1) Advanced Care Directives
      2) Senior Health
      3) Nutrition
      4) Physical Activity
      5) Heart Health
      6) Depression and Stress
      7) At-Risk Drinking
   b. Disease Management:
      1) Asthma
      2) Pre-Diabetes
      3) Diabetes
      4) Smoking Cessation
      5) Weight Management
   c. Perinatal:
      1) Prenatal Education
      2) Breastfeeding Support
      3) Family Planning/STI Prevention
      4) Injury Prevention
   d. Pediatric:
      1) Well-Baby and Immunization
      2) Developmental Screening
      3) Adolescent Health
      4) Healthy Lifestyles

G. IEHP ensures equal access to health care services for limited English proficient Medi-Cal

Members.[5,6] See Policy 9H1, "Cultural and Linguistic Services- Foreign Language Capabilities" for more information.

H. Although not required, Providers may refer Members to the IEHP Health Education Programs by submitting a Health Education request online~~http://throught/~~ through the secure IEHP Provider portal.

I. Members may self-refer to an IEHP Health Education Program by calling IEHP Member Services at (800) 440-4347/ TTY (800) 718-4347 or by registering via the online Member portal.

J. IEHP monitors Primary Care Provider (PCP) sites to ensure health education materials and resources are ready and accessible or made available to Members upon request, applicable to the practice and population served and available in threshold languages. Health education services must be documented in the Member's medical record in accordance with Policy 6A, "Facility Site Review and Medical Record Review Survey Requirements and Monitoring."~~.~~

[5] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 12, Civil Rights Act of 1964.

[6] ~~Department of Health Care Services (~~DHCS~~)~~ All Plan Letter (APL) 17-002, Health Education and Cultural and Linguistic Group Needs Assessment

15. HEALTH EDUCATION

A. Health Education

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1996
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

15. Health Education

B. Weight Management

APPLIES TO:[LN1]

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP offers the IEHP Weight Management Program to Members who are, or are at risk for, being overweight or obese.

PURPOSE:

A. To promote healthy dietary and physical activity habits for Members interested in preventing health problems related to obesity.

PROCEDURES:

A. Program Registration

1. IPAs or Providers may submit a Health Education request online through the secure IEHP Provider portal.
2. Members may access Weight Management activities themselves by calling Member Services at (800) 440-IEHP (4347) or visiting the online Member Portal at www.iehp.org.

B. Program Description

1. Members under the age of 18 must be accompanied by parent or guardian.
2. Activities are open to Members seeking weight loss surgery, but participation does not meet Utilization Management criteria for the authorization of any medical or surgical services.
3. Activities are not inclusive of a medically supervised weight loss program.
4. *Eat Healthy, Be Active* Community Workshops:
   a. Workshops are offered in San Bernardino and Riverside Counties.
   b. Program elements include education regarding nutrition, physical activity, and behavior change.
   c. Workshops are conducted in group settings, which include interactive modules, video presentations, and healthy cooking tips.
   d. Members may receive educational tools ~~and incentives~~ [TL2][JW3]at the end of each

workshop.[1]

D. Evaluation

1. IEHP Health Education Staff monitor processes and facilitation through program site visits.
2. Health Education Manager will conduct random site visits using standardized audit forms.

[1] ~~Department of Health Care Services (DHCS) All Plan Letter (APL) 16-005 (Revised) Supersedes Policy Letters (PL) 09-005 and 12-002, "Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, and Member Surveys"~~

15. Health Education

B. Weight Management

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2019
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, ~~2022~~2023

15. HEALTH EDUCATION

C. IEHP Family Asthma Program

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP offers the IEHP Family Asthma Program to Members who are diagnosed with asthma as well as their caregivers.[1]

B. IEHP ensures equal access to its health care services and programs for limited English proficient Members.[2] See Policy 9H1, "Cultural and Linguistic Services - Foreign Language Capabilities" for more information.

PURPOSE:

A. To provide self-management tools and intervention strategies to Members diagnosed with asthma.

PROCEDURES:

A. Program Registration
   1. Although not required, Providers may submit a Health Education request online through the secure IEHP Provider Portal.
   2. Members may register for the Asthma Program themselves by calling the Member Services Department at (800) 440-IEHP (4347) or online through the IEHP Member Portal at www.iehp.org.

B. Program Description
   1. Program topics include:
      a. Asthma symptoms;
      b. Environmental triggers;
      c. Interactive demonstration of Peak Flow Meter and Aero Chamber use;
      d. Controller vs. Rescue medications; and
      e. Asthma Action Plan.
   ~~2. Members who attend the Family Asthma Program may receive an educational tool or incentive for their participation.~~

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 8, Services for All Members
[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), ~~DHCS-IEHP Two Plan Contract,~~ Exhibit A, Attachment 9, Provision 12, Civil Rights Act of 1964

~~3.~~2. One (1) adult support person may attend with the Member. Support persons do not have to be IEHP Members or have asthma to attend.

~~4.~~3. Members under the age of 18 years old must be accompanied by a parent or guardian.

C. Program classes are instructed by certified educators, as determined appropriate by the Health Education Manager.

D. Evaluation

1. IEHP Health Education Staff monitor program processes and facilitation through program site visits.
2. The Health Education Manager will conduct random site visits for quality assurance purposes; assessments will be conducted using standardized audit forms.

15. HEALTH EDUCATION

C. IEHP Family Asthma Program

Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1999
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 202~~2~~3

15. HEALTH EDUCATION

D. IEHP Diabetes Self-Management Program

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. The IEHP Diabetes Self-Management Program is available to all Members who:
   1. Are not pregnant;
   2. Are at least 14 years of age; and
   3. Are diagnosed with diabetes.

PURPOSE:

A. To provide self-management tools and intervention strategies to Members diagnosed with Diabetes.[1]

PROCEDURES:

A. Program Registration
   1. Although not required, Providers may submit a Health Education request online through the secure IEHP Provider Portal.
   2. Members can register for the Diabetes Self-Management Program themselves by calling the Member Services Department at (800) 440-IEHP (4347) or through the online Member Portal at www.iehp.org.

B. Program Description
   1. Program curriculum is adapted from the American Diabetes Educator Association (AADE). Program topics include:
      a. Glucose level monitoring;
      b. A1C tracking;
      c. Medication adherence;
      d. Healthy eating and Meal planning; and
      e. Benefits of physical activity.

[1] Department of Health Care Services (DHCS)-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 8, Services for All Members

2. To promote participation and enhance meaningful engagement, Members who attend the Diabetes Self-Management Program may receive an educational tool ~~or incentive~~ in class sessions~~.~~[2].
3. One (1) support person may participate in the activities with the Member. Support persons do not have to be IEHP Members or have diabetes to attend.
4. Members under the age of 18 must be accompanied by a parent or guardian.

C. Program classes are instructed by a Diabetes Educator, Registered Nurse, Registered Dietitians, Pharmacists, or other certified Health Educators, as deemed appropriate by the Health Education Manager.

D. IEHP ensures that the instructors are using an evidence-based curriculum and activities that adhere to the American Diabetes Association Guidelines (ADA), and American Association of Diabetes Educators (AADE).

E. Evaluation

1. IEHP Health Education Staff monitor program processes and facilitation through program site visits.
2. Health Education Manager will conduct random site visits for quality assurance purposes; assessments will be performed using standardized audit forms.

~~[2] Department of Health Care Services (DHCS) All Plan Letter (APL) 16-005 (Revised) Supersedes Policy Letters (PL) 09-005 and 12-002, "Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, and Member Surveys"~~

15. HEALTH EDUCATION

D. IEHP Diabetes Self-Management Program

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	September 1, 1999
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

15. HEALTH EDUCATION

E. Perinatal Program

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP offers the IEHP Perinatal Program ~~is available~~ at no cost to Members who are:
   1. Pregnant at the time of registration; or
   2. Contemplating pregnancy.

PURPOSE:

A. To deliver health education programming which promotes a healthy pregnancy and birth outcome.

PROCEDURES:

A. Program Registration
   1. Although not required, IPAs or Providers may submit a Health Education request online through the secure IEHP Provider Portal.
   2. Members may access perinatal services themselves by calling Member Services at (800) 440-IEHP (4347) or through the online Member Portal at www.iehp.org.

B. Program Description:
   1. Becoming a Mom Workshop
      a. Workshops are offered in San Bernardino and Riverside Counties.
      b. Program elements will include prenatal/postpartum care, nutrition, injury prevention, well-baby checkups, immunizations, and community resources.
      c. Workshops are conducted in group settings which include interactive modules, video presentations, and safety demonstrations.
      d. To promote participation and enhance meaningful engagement, Members may receive educational tools ~~and/or incentive items~~ at the end of the workshop.[1]
   2. Baby n' Me Smartphone Application:
      a. The application is available for free download from the Apple App Store or Google Play Store in English and Spanish versions.
      b. Application features include tracking tools, interactive media, anticipatory guidance,

[1] ~~Department of Health Care Services (DHCS) All Plan Letter (APL) 16-005 (Revised) Supersedes Policy Letters (PL) 09-005 and 12-002, "Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, and Member Surveys"~~

evidence-based prevention tips, and resource linkages.

c. Eligible Members must verify their active Member identification numbers and dates of birth to obtain the application. Members must agree to the Terms and Conditions and a Privacy Policy when downloading the digital application on their personal devices.

d. Eligible Members can access all available features of the application without additional costs.

e. Members may participate in optional surveys, text back campaigns, or interactive quizzes. They may receive incentive items for participating.[2]

3. Loving Support Breastfeeding Helpline Assistance:

a. Provide breastfeeding support through Helpline services for Members.

b. Services are provided in a culturally competent manner in English and Spanish. ~~threshold languages.~~

C. Evaluation

1. Workshops and Groups

a. IEHP Health Education Staff monitor processes and facilitation through program site visits.

b. The Health Education Manager will conduct random site visits using standardized audit forms.

2. Digital Application

a. Member level reports will be provided by the application developer and will be securely transmitted. Data may be transmitted to IEHP via Secure File Transfer Protocol (SFTP), secure email, or directly via client configured Application Programming Interface (API).

b. Reports will include end-user data which details how the Member interacts with the features of the application. For Members with certain high-risk pregnancy conditions (e.g. hypertensive disorders, a previous preterm birth, a mood disorder, or a substance use disorder) and who agree to receive contact from an IEHP Team Member, the Health Education Department will provide a monthly report to the Behavioral Health & Care Management Department for telephonic follow up.

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2020

[2] Department of Health Care Services (DHCS)~~DHCS~~ All Plan Letter (APL) 16-005 (Revised) Supersedes Policy Letters (PL) 09-005 and 12-002, "Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, and Member Surveys"

15. HEALTH EDUCATION

E. Perinatal Program

Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

15. HEALTH EDUCATION

F. Individual Health Education Behavioral Assessment / Staying Healthy Assessment

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. IEHP and its IPAs cover and ensure the provision of an Initial Health Assessment (IHA) on each Member within the following timelines:[1]

1. Sixty (60) calendar days of enrollment for Members under 18 months of age; or
2. One hundred twenty (120) calendar days of enrollment for Members aged 18 months and older.

See Policy 10A, "Initial Health Assessment" for more information.

DEFINITION:

A. Initial Health Assessment (IHA) - The IHA is a comprehensive assessment that is completed during the Member's initial encounter(s) with a selected or assigned Primary Care Provider (PCP), appropriate medical specialist, or non-physician medical provider that is documented in the Member's medical record. The IHA consists of a history and physical examination and an Individual Health Education Behavioral Assessment (IHEBA) that enables a ~~Primary Care Provider (~~PCP~~)~~ to comprehensively assess the Member's current acute, chronic, and preventive health needs and identify those Members whose health needs require coordination with appropriate community resources and other agencies.[2,3]

PROCEDURES:

A. IEHP PCPs will administer the IHEBA using the "Staying Healthy Assessment" (SHA) form. The SHA consists of seven (7) age-specific pediatric questionnaires and two (2) adult questionnaires. These are available in English and in all Medi-Cal threshold languages.

B. PCP Responsibilities[4]

1. PCPs are responsible for assuring the IHEBA is administered as part of the IHA and within the timeframes outlined in this policy. The effective date of enrollment is the first day of the month following notification by the Medi-Cal Eligibility Data System (MEDS) that a Member is eligible to receive services from IEHP. Current Members who have not completed an updated SHA must complete it during the next preventive care office visit

[1] Department of Health Care Services (DHCS) Policy Letter (PL) 08-003, "Initial Comprehensive Health Assessment"
[2] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 3, Initial Health Assessment (IHA)
[3] DHCS PL 08-003
[4] DHCS PL 13-001, "Requirements for the Staying Healthy Assessment/Individual Health Education Behavioral Assessment."

(e.g. well-baby, well-child, well-woman exam). Please see Table 1: SHA Periodicity table in this policy.

2. Existing Members who missed the one hundred twenty (120) calendar day assessment must have the IHEBA administered at their next scheduled non-acute care visit, but no later than their next scheduled health screening exam.
3. PCPs must ensure the Member or their parent or guardian completes the appropriate age-specific form and review the completed SHA with the Member. Assessments must be completed by the parent/guardian for Members below the age of 12 years. For Members between the ages of 12-17 years, Adult and Senior forms must be completed by the Member to preserve confidentiality.
4. In the case of Members who are unable to complete the SHA form on their own, or prefer assistance, the PCP must provide a staff person to administer the form, read the questions to the Member, and record the Member's responses.
5. The completed SHA form must be filed in the Member's chart as part of the permanent medical record.
6. The PCP must review the completed SHA with the Member, prioritize each Member's health education needs, and initiate discussion and counseling regarding high-risk behaviors the Member identified in the assessment. Clinic staff members, as appropriate, may assist a PCP in providing counseling and following up if the PCP supervises the clinical staff members and directly addresses medical issues.
7. The PCP must review the SHA with the Member during the years between re-administration of a new SHA assessment. The review should include discussion, appropriate patient counseling, and regular follow-up regarding risk reduction plans.
8. The PCP must sign, print name and date every newly administered SHA to verify it was reviewed with the patient. PCP must complete the "Clinical Use Only" section to indicate topics discussed and assistance provided. Subsequent annual reviews must be signed and dated by PCP in the "SHA Annual Review" section to verify the annual review was conducted with the patient.
9. The assessment form must be re-administered at the appropriate age intervals:[5]
    a. Members 1-17 years of age must complete the SHA during the first scheduled preventive care office visit upon reaching a new SHA age group. PCPs must review the SHA annually with the patient (parent/guardian or adolescent) in the intervening years before the patient reaches the next age group.
    b. Adolescents (12-17 years) should complete the SHA without parent/guardian assistance beginning at 12 years of age, or at the earliest age possible to increase the likelihood of obtaining accurate responses to sensitive questions. The PCP will

[5] DHCS PL 13-001

determine the most appropriate age, based on discussion with the parent/guardian and the family's ethnic/cultural background.

c. There are no designated age ranges for the adult and senior assessments, although the adult assessment is intended for use by 18 to 55 years old. The age at which the PCP should begin administering the senior assessment to a Member should be based on the patient's health and medical status, and not exclusively on the patient's age.

Table 1: SHA Periodicity[6]

	Periodicity	Initial SHA Administration	Subsequent SHA Administration		SHA Review
DHCS Form Numbers	Age Groups	Within 120 Days of Enrollment	After Entering New Age Group	Every 3-5 Years	Annually (intervening years between administration of new assessment)
DHCS 7089 A	0-6 Months	√	√		
DHCS 7089 B	7-12 Months	√	√		
DHCS 7089 C	1-2 Years	√	√		√
DHCS 7089 D	3-4 Years	√	√		√
DHCS 7089 E	5-8 Years	√	√		√
DHCS 7089 F	9-11 Years	√	√		√
DHCS 7089 G	12-17 Years	√	√		√
DHCS 7089 H	Adult	√		√	√
DHCS 7089 I	Senior	√		√	√

[6] DHCS PL 13-001

10. The Member's refusal to complete the SHA must be documented on the age-appropriate SHA questionnaire by:[7]
    a. Entering the Member's name (or person completing the form), date of birth, and date of refusal in the header section of the questionnaire;
    b. Checking the box "SHA Declined by Patient;"
    c. Having the PCP sign, print his or her name, and date the "Clinic Use Only" section of the SHA; and
    d. Keeping the SHA refusal in the Member's medical record.
11. Monitoring of compliance with IHA/IHEBA requirements is performed during the initial and periodic Medical Record Review survey. See Policy 6A, "Facility Site Review and Medical Record Review Survey" for more information.

C. Tobacco Prevention and Cessation[8]

1. The SHA includes screening questions regarding Member's smoking status and/or exposure to tobacco smoke.
    a. Members are to be assessed on their tobacco use status on an annual basis unless an assessment needs to be re-administered based on the SHA periodicity schedule.
    b. PCPs are required to provide interventions, including education or counseling, to prevent initiation of tobacco use in school-aged children and adolescents. Services shall be provided in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule and anticipatory guidance, as periodically updated. Additionally, since secondhand smoke can be harmful to children, counseling parents who smoke, in a pediatric setting, is also recommended.
    c. Providers are to review the questions on tobacco with the Member. This constitutes as individual counseling.
    d. Current tobacco use is to be documented in the medical record at every visit for Members of all ages.
2. For Tobacco Cessation, IEHP encourages Providers to implement the following interventional approach:
    a. Use a validated behavior change model to counsel Members who use tobacco products. Training materials on the following examples may be requested from the Provider Relations Team or accessed online on through the non-secure Provider

[7] DHCS PL 13-001
[8] DHCS All Plan Letter (APL) 16-014 Supersedes PL 14-006, "Comprehensive Tobacco Prevention and Cessation Services for Medi-Cal Beneficiaries"

~~portal~~Portal:

1) Use of the "5 A's" – Ask, Advise, Assess, Assist, and Arrange; and

2) Use of the "5 R's" – Relevance, Risks, Rewards, Roadblocks, and Repetition.

b. Members ~~are able to~~shall receive a minimum of four (4) counseling sessions of at least ten (10) minutes/session. Members may choose individual or group counseling conducted in person or by telephone.

1) Individual, group, and telephone counseling is offered at no cost to Members who wish to quit smoking, whether or not those Members opt to use tobacco cessation medications.

c. Two (2) quit attempts per year are covered without prior authorization and without any mandatory breaks between quit attempts.

1) The list of appropriate Current Procedure Terminology (CPT) and International Classification of Diseases (ICD) codes for tobacco may be requested through the Provider Relations Team or accessed online through the non-secure Provider Portal.

d. Members are to be referred to the California Smoker's Helpline (1-800-NO-BUTTS by phone or www.nobutts.org online) or other comparable quit-line service. Providers are encouraged to use the Helpline's web referral, or if available in their area, the Helpline's e-referral system.

e. Providers are strongly encouraged to implement the recommendations from the U.S. Department of Health and Human Services Public Health Service (USPHS) "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update." This document is accessible at: https://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/update/index.html.

f. Based on the Member's behavioral risks and willingness to make lifestyle changes, the PCP should provide tailored health education counseling, intervention, referral, and follow-up. Whenever possible, the PCP and the Member should develop a mutually agreed-upon risk reduction plan.

D. IEHP and IPA Responsibilities[9]

1. IEHP and its IPAs must ensure that all PCPs receive access to the age-appropriate SHA forms.

2. IEHP provides all IPAs and PCPs access to the SHA forms in designated threshold languages (English, Spanish, Chinese & Vietnamese) as follows:

a. Through the annual IEHP Provider Policies and Procedure Manual (See

[9] DHCS-IEHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 10, Provision 8, Services for All Members

Attachments, "SHA Form – Children 0-6 Months ~~(English & Spanish)~~," "SHA Form – Children 7-12 Months ~~(English & Spanish)~~," "SHA Form – Children 1-2 Years ~~(English & Spanish)~~," "SHA Form – Children 3-4 Years ~~(English & Spanish)~~," "SHA Form – 5-8 Years ~~(English & Spanish)~~," "SHA Form – Children 9-11 Years ~~(English & Spanish)~~," "SHA Form – 12-17 Year ~~(English & Spanish)~~," "SHA Form – Adult ~~(English & Spanish)~~," and "SHA Form – Senior ~~(English & Spanish)~~" in Section 15);

b. Online through IEHP's website at www.iehp.org; and

c. Through the Department of Health Care Services (DHCS) website at https://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthyAssessmentQuestionnaires.aspx

3. IEHP and its IPAs must assist PCPs in providing health education services as indicated by Members on their SHA. This includes authorization of necessary referrals and provision of required education services.

E. SHA Electronic Formats[10]

1. When a Provider or IPA plans to use the SHA in an alternate format (electronic or another paper-based format) they must ensure the following:

a. All SHA questions for the specific age group are included verbatim;

b. Referencing the most current version available on the SHA Webpage; and

c. Inform~~s~~ their contracted health plan at least one (1) month before they plan to implement the SHA in an electronic or alternative format.

F. Alternative IHEBA[11]

1. If Providers plan to use an alternative IHEBA, the tool will be evaluated by IEHP. If IEHP approves the tool, a justification for the use and a copy of the tool will be submitted by IEHP's Compliance Department to DHCS Medi-Cal Managed Care Division (MMCD) (See Attachment, "Alternative Individual Health Education Behavioral Assessment (IHEBA)" in Section 15). The tool will be comparable to the latest version of the SHA including: content and specific risk factors, periodicity and schedule for administration, documentation of administration, re-administration, annual review and required follow-up for identified risk factors. The approved alternative IHEBA will be translated into IEHP threshold languages and made available to the PCP. Previously approved alternative IHEBAs will be re-submitted to MMCD for approval every three (3) years.

[10] DHCS PL 13-001
[11] Ibid.

G. Bright Futures Assessment[12]

1. If the PCPs intend to implement American Academy of Pediatrics (AAP) Bright Futures, IEHP's Compliance Department will notify DHCS MMCD one (1) month prior to the use of the Bright Futures assessment. The most current version of Bright Futures will be used and administered according to Bright Futures guidelines. Providers will be asked for which age groups they will be using the Bright Futures assessment tools. Documentation and follow up will be assessed the same as the IHEBA/SHA using the DHCS Medical Record Review scoring method. The Bright Futures forms will be translated into IEHP threshold languages and made available to the Providers.

H. Provider Training

1. IEHP provides all PCPs and IPAs with education and training on the implementation of the "Staying Healthy Assessment" using the standardized SHA Provider Training materials. See Policy 18G, "Provider Resources". Training materials include:[13]
   a. IHEBA contract and documentation requirements;
   b. Training on how to set timelines for administration, review, and re-administration;
   c. Instructions on how to use the SHA or DHCS-approved alternative assessment; and
   d. Specific information and resources for providing culturally and linguistically appropriate patient health education services/interventions.
2. All PCPs are trained by IEHP Provider Service Representatives regarding patient referral procedures.
3. Additional training is available to Providers on an as needed basis, either via web or face to face platform, by a Provider Services Representative or Quality Management Nurse Educator/Quality Program Nurse. All new PCPs receive SHA training and are informed that the SHA forms are available on IEHPs Provider Portal (see Attachment "Staying Healthy Assessment Instruction Sheet for Provider Office" in Section 15).
4. PCPs are informed of the mandatory SHA training via blast fax which includes: the mandated training deadline date, instructions on how to access the web training and the Proof of Training Form. The Proof of training form must be signed and submitted to IEHP. Additional contact information may be submitted to the IEHP Provider Relations Team should the PCP need additional assistance with the SHA training.
5. IEHPs Provider Services Department tracks all completed SHA trainings by the receipt of the signed Proof of Training Forms. PCPs who have not completed the Proof of Training Form will be contacted by a Provider Services Representative.
6. IEHP provides resources and training to PCPs and subcontractors to ensure the delivery

[12] Ibid.
[13] DHCS PL 13-001

of culturally and linguistically appropriate patient health education services and to ensure that the special needs of vulnerable populations, including SPDs and persons with limited English skills, are addressed in the delivery of patient services.[14]

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on file*	**Original Effective Date:**	January 1, 2001

[14] ~~DHCS PL 13-001~~Ibid.

15. HEALTH EDUCATION

F. Individual Health Education Behavioral Assessment / Staying Healthy Assessment

Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2023~~2~~

15. HEALTH EDUCATION

G. Pediatric Health and Wellness

APPLIES TO:

A. This policy applies to all IEHP Members.

POLICY:

A. IEHP offers Pediatric Health and Wellness programs and activities to Members, who are aged ~~19~~ 21 years or younger.

PURPOSE:

A. To deliver programming that promotes healthy growth and development, including wholesome lifetime habits, accessing appropriate health services, and preventive screenings.

PROCEDURES:

A. Program Registration

1. Although not required, a Provider can submit a Health Education request online through the secure IEHP Provider Portal.
2. Members must be aged ~~19~~ 21 years or younger at the time of participation in Pediatric Health and Wellness programs and activities.
3. Members under 18 years of age must have the consent of their parent or guardian to participate.
4. Members (or their parents/ guardians) may access Pediatric Health and Wellness activities themselves by calling Member Services at (800) 440-IEHP (4347) or through the secure IEHP Member Portal at www.iehp.org.

B. Program Description

1. *Circle Time Classes*
   a. Workshops are offered in San Bernardino and Riverside Counties.
   b. Program educational elements include interactive play to help parents identify developmental milestones.
   c. Group sessions include physical activity, play, and anticipatory guidance.
2. *Early and Periodic Screening, Diagnostic and Treatment Support*
   a. Early development screening support to Members, which includes assisting Members in filling out screening tools/forms;
   b. Secure data file sharing within the HelpMeGrow network to ensure Providers have

access to screening results; and

c. Educational tools for Members and Providers.

~~3. *Adolescent Workshops*~~

~~a. Workshops are offered in San Bernardino and Riverside Counties.~~

~~b. Program topics include healthy eating, mental health, sexually transmitted infections, contraception, resilience building and/or other topics relevant to adolescents.~~

~~c. Members may receive promotional items, educational tools, or incentives for their participation.~~[1]

C. IEHP ensures equal access to its health care services and programs for Members with limited English ~~proficient Members~~proficiency.[2] See Policy 9H1, "Cultural and Linguistic Services-Foreign Language Capabilities" for more information.

D. Evaluation

1. IEHP Health Education Staff monitor processes and facilitation through program site visits.
2. Health Education Manager will conduct random site visits using standardized audit forms.

~~[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 16-005 (Revised) Supersedes Policy Letters (PL) 09-005 and 12-002, "Requirements for Use of Non-Monetary Member Incentives for Incentive Programs, Focus Groups, and Member Surveys"~~

[2] DHCS-IEHP Two Plan Contract, Exhibit A, Attachment 9, Provision 12, Civil Rights Act of 1964

15. HEALTH EDUCATION

G. Pediatric Health and Wellness

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2019
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, 2022

15. Health Education

H. Diabetes Prevention Program

APPLIES TO:

A. This policy applies to all IEHP Medi-Cal Members.

POLICY:

A. In accordance with Centers for Disease Control and Prevention (CDC) guidelines, IEHP offers the Diabetes Prevention Program (DPP), an interactive program focused on lifestyle changes for Members with prediabetes to prevent or delay the onset of Type 2 Diabetes. Members must meet DPP eligibility criteria developed by the Centers for Medicare and Medicaid Services (CMS) in alignment with the CDC DPP criteria and in accordance with the Department of Health Care Services (DHCS) All Plan Letter (APL) 18-018, "Diabetes Prevention Program".[1]

B. IEHP Members may access DPP services at no cost and without prior authorization.

C. IEHP ensures equal access to its health care services and programs for Members with limited English ~~proficient~~ proficiency~~Members~~.[2] See Policy 9H1, "Cultural and Linguistic Services-Foreign Language Capabilities" for more information.

DEFINITION:

A. Diabetes Prevention Program (DPP) - The Diabetes Prevention Program (DPP) is an evidence-based disease prevention program developed by the Centers for Disease Control and Prevention (CDC) and is a medical benefit covered by IEHP.[3]

PURPOSE:

A. To provide a lifestyle change program to prevent onset of Type 2 Diabetes.[4]

PROCEDURES:

A. Program Registration

1. Providers may refer IEHP Members to a DPP supplier without prior authorization. Providers can access a list of active DPP suppliers for IEHP, that is maintained by the Health Education Department, by going online at www.iehp.org.

2. The benefit may be offered as often as necessary, but the Member's medical record must

[1] Department of Health Care Services (DHCS) All Plan Letter (APL) 18-018, "Diabetes Prevention Program"
[2] DHCS-IEHP Two Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 9, Provision 12, Civil Rights Act of 1964
[3] https://www.cdc.gov/diabetes/prevention/lifestyle-program/requirements.html
[4] Ibid.

indicate that the Member's medical condition or circumstance warrants repeat or additional participation in the DPP benefit.

B. Program Description:

1. Consistent with the CDC curriculum, the DPP is a longitudinal program that consists of at least twenty-two (22) group sessions.
2. Each session is for one (1) hour and topics include:
   a. Self-monitoring diet and physical activity;
   b. Building self-efficacy;
   c. Social support for maintaining lifestyle changes; and
   d. Problem solving strategies for overcoming challenges.

C. Evaluation

1. IEHP Health Education Department staff will monitor process and facilitation through program site visits.
2. The Health Education Manager will review quarterly reports.
3. IEHP Health Education Department Staff will perform annual evaluation for select DPP suppliers.

15. Health Education

H. Diabetes Prevention Program

INLAND EMPIRE HEALTH PLAN		
Chief Approval: *Signature on File*	**Original Effective Date:**	January 1, 2019
Chief Title: Chief Medical Officer	**Revision Date:**	January 1, ~~2022~~2023

15. HEALTH EDUCATION

Attachments

DESCRIPTION	POLICY CROSS REFERENCE
Alternate Individual Health Education Behavioral Assessment (IHEBA)~~)~~	15F
~~SHA Form – Children 0-6 months~~	
SHA Form – Children 0-6 months	
a. English	15F
b. Spanish	15F
c. Chinese	15F
d. Vietnamese	15F
~~a. Spanish~~	~~15F~~
~~b. Chinese~~	~~15F~~
~~b. Vietnamese~~	~~15F~~
SHA Form – Children 7-12 months	
a. English	15F
b. Spanish	15F
c. Chinese	15F
d. Vietnamese	15F
~~a. Spanish~~	~~15F~~
~~b. Chinese~~	~~15F~~
~~b. Vietnamese~~	~~15F~~
SHA Form – Children 1-2 years	
a. English	15F
b. Spanish	15F
c. Chinese	15F
d. Vietnamese	15F
~~a. Spanish~~	~~15F~~
~~b. Chinese~~	~~15F~~
~~b. Vietnamese~~	~~15F~~
SHA Form – Children 3-4 years	
a. English	15F
b. Spanish	15F
c. Chinese	15F
d. Vietnamese	15F
~~a. Spanish~~	~~15F~~
~~b. Chinese~~	~~15F~~
~~b. Vietnamese~~	~~15F~~
SHA Form – Children 5-8 years	
a. English	15F
b. Spanish	15F
c. Chinese	15F
d. Vietnamese	15F
~~a. Spanish~~	~~15F~~
~~b. Chinese~~	~~15F~~

~~b. Vietnamese~~	~~15F~~
SHA Form – Children 9-11 years	
a. English	15F
b. Spanish	15F
c. Chinese	15F
d. Vietnamese	15F
SHA Form – Children 12-17 years	
a. English	15F
b. Spanish	15F
~~Spanish~~	15F
~~Chinese~~	~~15F~~
~~b. Vietnamese~~	~~15F~~
~~SHA Form – Children 12-17 years~~	~~15F~~
~~a. English~~	~~15F~~
~~Spanish~~	~~15F~~
Chinese	~~15F~~
~~b.~~a. ~~Vietnamese~~	~~15F~~
b. Vietnamese	15F
SHA Form – Adult	
a. English	15F
b. Spanish	15F
c. Chinese	15F
d. Vietnamese	15F
SHA Form – Senior	
e. English	15F
f. Spanish	15F
g. Chinese	15F
h. Vietnamese	15F
Staying Healthy Assessment (SHA) Instruction Sheet for Provider Office	15F
~~SHA Form – Adult~~	
~~a. English~~	~~15F~~
~~Spanish~~	~~15F~~
~~Chinese~~	~~15F~~
~~b. Vietnamese~~	~~15F~~
~~SHA Form – Senior~~	
~~a. English~~	~~15F~~
~~Spanish~~	~~15F~~
~~Chinese~~	~~15F~~
~~b. Vietnamese~~	~~15F~~
~~Staying Healthy Assessment (SHA) Instruction Sheet for Provider Office~~	~~15F~~

15. HEALTH EDUCATION

Attachments

Alternative Individual Health Education Behavioral Assessment (IHEBA)

Review and Approval Form

Health Plan Name: _____ Date Received: _____

Health Plan Contact: _____ Phone: _____ Email: _____

_____	_____	_____
(Name or Title of Alternative IHEBA)	*(Date Developed)*	*(Date Updated):*

☐ APPROVED AS SUBMITTED*

☐ ADDITIONAL INFORMATION REQUESTED (AIR)
(See next page)

**Approved alternative IHEBA must be resubmitted to MMCD for review and approval every three years (or no later than):* _____

Age Groups:

Providers/Provider Groups:

Approved administration, documentation and follow up process:

REVIEWER: HEALTH EDUCATION CONSULTANT III, SPECIALIST

(Name)	*(Signature)*	*(Date)*

Requirements for Approving an Alternative IHEBA
Policy Letter 13-001 (Revised)

Name of the organization/company that developed the Alternative IHEBA? _____

A.	Content and Risk Factors	Yes	AIR	Additional Information Requested (Explanation)
	Does the alternative IHEBA include the content and specific risk factors included in the most current version of the Staying Healthy Assessment (SHA).?			
B.	**Periodicity and Administration Schedule**	**Yes**	**AIR**	
	Is the periodicity and schedule for administration of the alternative IHEBA, at a minimum, comparable to the SHA?			
C.	**Documentation and Verification**	**Yes**	**AIR**	
	Is the documentation process for the administration, re-administration, and annual review of the alternative IHEBA included? If so, is it similar (or comparable) to the SHA?			
D.	**Threshold Language Availability**	**Yes**	**AIR**	
	Will the alternative IHEBA be made available in the threshold languages of its members?			
E.	**Additional Questions or Comments**			

Staying Healthy Assessment

0 – 6 Months

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ 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 breastfeed your baby?	Yes	No	Skip	Nutrition
2	Are you concerned about your baby's weight?	No	Yes	Skip	Physical Activity
3	Does your baby watch any TV?	No	Yes	Skip	
4	Does your home have a working smoke detector?	Yes	No	Skip	Safety
5	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
6	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
7	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
8	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
9	Do you always put your baby to sleep on her/his back?	Yes	No	Skip	
10	Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Skip	

11	Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Skip	
12	Is the car seat you use the right one for the age and size of your baby?	Yes	No	Skip	
13	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
14	Do you give your baby a bottle with anything except formula, breast milk, or water?	No	Yes	Skip	Dental Health
15	Does your baby spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
16	Do you have any other questions or concerns about your baby's health, development, or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

Evaluación de Salud

(Staying Healthy Assessment)

0 – 6 meses *(0 – 6 Months)*

Nombre del niño (primer nombre y apellido)	Fecha de nacimiento	☐ Mujer ☐ Hombre	Fecha de hoy	¿Asiste a una guardería? ☐ Sí ☐ No
Persona que completa el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			¿Necesita ayuda para completar el formulario? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no sabe la respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre algún punto de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only:
1	¿Amamanta a su bebé? *Breastfeeds baby?*	Sí *Yes*	No	Omitir *Skip*	Nutrition
2	¿Le preocupa el peso de su bebé? *Concerned about baby's weight?*	No	Sí *Yes*	Omitir *Skip*	Physical Activity
3	¿Su bebé mira televisión? *Baby watches any TV?*	No	Sí *Yes*	Omitir *Skip*	
4	En su hogar, ¿hay un detector de humo que funcione? *Home has working smoke detector?*	Sí *Yes*	No	Omitir *Skip*	Safety
5	¿Ha cambiado la temperatura del agua a tibia (menos de 120 grados)? *Water temperature turned down to low-warm?*	Sí *Yes*	No	Omitir *Skip*	
6	Si en su hogar hay más de un piso, ¿tiene protección de seguridad en las ventanas y accesos a las escaleras? *Safety guards on window and gates for stairs in multi-level home?*	Sí Yes	No	Omitir Skip	
7	En su hogar, ¿los materiales de limpieza, medicamentos y fósforos están en un lugar cerrado con llave? *Cleaning supplies, medicines, and matches locked away?*	Sí Yes	No	Omitir *Skip*	
8	En su hogar, ¿está pegado cerca del teléfono el número del Centro de intoxicaciones (800-222-1222)? *Home has phone # of the Poison Control Center posted by phone?*	Sí Yes	No	Omitir *Skip*	
9	¿Siempre acuesta a su bebé boca arriba para dormir? *Always puts baby to sleep on her/his back?*	Sí Yes	No	Omitir *Skip*	
10	Cuando su bebé está en la tina, ¿permanece con él en todo momento? *Always stays with baby in the bathtub?*	Sí Yes	No	Omitir *Skip*	

11	¿Su bebé siempre viaja en un asiento de seguridad para automóvil orientado hacia atrás, en el asiento de atrás? *Always places baby in a rear facing car seat in the back seat?*	Sí Yes	No	Omitir *Skip*	
12	¿El asiento de seguridad para automóvil que utiliza es el adecuado para la edad y el tamaño de su bebé? *Car seat used is correct size for age and size of baby?*	Sí Yes	No	Omitir *Skip*	
13	¿Su bebé pasa tiempo en un hogar donde hay un revólver? *Baby spends time in home where a gun is kept?*	No	Sí Yes	Omitir *Skip*	
14	En el biberón de su bebé, ¿coloca algo que no sea fórmula, leche materna o agua? *Gives baby a bottle with anything in it except formula, breast milk, or water?*	No	Sí Yes	Omitir *Skip*	Dental Health
15	¿Su bebé pasa tiempo con alguna persona que fuma? *Baby spends time with anyone who smokes?*	No	Sí Yes	Omitir *Skip*	Tobacco Exposure
16	¿Tiene alguna pregunta o inquietud sobre la salud, el desarrollo o el comportamiento de su bebé? *Any other questions or concerns about baby's health, development, or behavior?*	No	Sí Yes	Omitir *Skip*	Other Questions

Si la respuesta es afirmativa, describa:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

保持健康評估

(Staying Healthy Assessment)

0 到 6 個月 *(0 – 6 Months)*

孩童姓名（名和姓）	出生日期	☐女 ☐男	當日日期	在托兒所嗎? ☐是 ☐否
填表人	☐父母 ☐親屬 ☐朋友 ☐監護人 ☐其他（請註明）			需要幫助填寫本表格嗎？☐是 ☐否

請儘量回答本表格所有的問題。如果您不知道答案或不想回答，請圈選「跳過」。如果對本表格有任何問題，請一定要問醫生。您的回答將與您的醫療記錄一同受到保護。

需要翻譯員嗎？☐是 ☐否

					Clinic Use Only:
1	您用母乳哺育您的寶寶嗎？ *Breastfeeds baby?*	是 *Yes*	否 *No*	跳過 *Skip*	Nutrition
2	您擔心寶寶的體重嗎？ *Concerned about baby's weight?*	否 *No*	是 *Yes*	跳過 *Skip*	Physical Activity
3	您的寶寶看電視嗎？ *Baby watches any TV?*	否 *No*	是 *Yes*	跳過 *Skip*	
4	您家裡有功能正常的煙霧偵測器嗎？ *Home has working smoke detector?*	是 *Yes*	否 *No*	跳過 *Skip*	Safety
5	您有沒有將水溫調到低溫（低於 120 度）？ *Water temperature turned down to low-warm?*	是 *Yes*	否 *No*	跳過 *Skip*	
6	如您家是樓房，您有在窗戶和樓梯入口裝置安全防護？ *Safety guards on window and gates for stairs in multi-level home?*	是 *Yes*	否 *No*	跳過 *Skip*	
7	您有將家裡的清潔用品、藥物和火柴鎖起來嗎？ *Cleaning supplies, medicines and matches locked away?*	是 *Yes*	否 *No*	跳過 *Skip*	
8	您家裡電話旁邊貼著毒物控制中心（800-222-1222）的電話號碼嗎？ *Home has phone # of the Poison Control Center posted by phone?*	是 *Yes*	否 *No*	跳過 *Skip*	
9	您是否總是讓寶寶仰躺著睡覺？ *Always puts baby to sleep on her/his back?*	是 *Yes*	否 *No*	跳過 *Skip*	
10	寶寶洗盆浴時您是否一直在她/他身邊？ *Always stays with baby in the bathtub?*	是 *Yes*	否 *No*	跳過 *Skip*	

11	您是否總是將寶寶放置在車後座後向的安全座椅上？ *Always places baby in a rear facing car seat in the back seat?*	是 *Yes*	否 *No*	跳過 *Skip*	
12	您所使用的安全座椅是否適用於您寶寶的年齡和大小？ *Car seat used is correct size for age and size of baby?*	是 *Yes*	否 *No*	跳過 *Skip*	
13	您寶寶會待在有槍枝的家中嗎？ *Baby spends time in home where a gun is kept?*	否 *No*	是 *Yes*	跳過 *Skip*	
14	您是否在奶瓶中放嬰兒奶、母乳或水以外的東西餵給您寶寶喝？ *Gives baby a bottle with anything in it except formula, breast milk, or water?*	否 *No*	是 *Yes*	跳過 *Skip*	Dental Health
15	您寶寶是否有時與抽煙的人在一起？ *Baby spends time with anyone who smokes?*	否 *No*	是 *Yes*	跳過 *Skip*	Tobacco Exposure
16	您是否有任何其他關於您寶寶健康、發育或行為上的問題或疑慮？ *Any other questions or concerns about baby's health, development or behavior?*	否 *No*	是 *Yes*	跳過 *Skip*	Other Questions

若回答是，請描述：

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

Đánh Giá về Giữ Gìn Sức Khỏe

(Staying Healthy Assessment)

0 – 6 Tháng *(0 – 6 Months)*

Tên của Trẻ (tên & họ)	Ngày Sinh	☐ Nữ ☐ Nam	Hôm Nay là Ngày	Có tham gia Dịch Vụ Chăm Sóc Trẻ Em/Ban Ngày không? ☐ Có ☐ Không
Người Điền Mẫu	☐ Phụ Huynh ☐ Họ Hàng ☐ Bạn Bè ☐ Người Giám Hộ ☐ Người Khác (Ghi Rõ)			Cần Hỗ Trợ Điền Mẫu? ☐ Có ☐ Không

Vui lòng trả lời tất cả các câu hỏi trong mẫu này một cách tốt nhất có thể. Khoanh tròn "Bỏ Qua" nếu quý vị không biết câu trả lời hoặc không muốn trả lời. Hãy đảm bảo rằng quý vị sẽ hỏi bác sỹ nếu có thắc mắc liên quan đến bất kỳ điều gì trong mẫu này. Tất cả câu trả lời của quý vị sẽ được bảo vệ như một phần hồ sơ y tế của quý vị.

Cần Phiên Dịch? ☐ Có ☐ Không

					Clinic Use Only:
					Nutrition
1	Quý vị có cho con bú sữa mẹ không? *Breastfeeds baby?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
					Physical Activity
2	Quý vị có lo lắng về cân nặng của con không? *Concerned about baby's weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
3	Con của quý vị có xem TV không? *Baby watches any TV?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
					Safety
4	Nhà quý vị có thiết bị báo khói đang hoạt động không? *Home has working smoke detector?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
5	Quý vị đã đặt nhiệt độ nước xuống mức ấm (dưới 120 độ) chưa? *Water temperature turned down to low-warm?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
6	Nếu nhà quý vị có nhiều hơn một tầng, quý vị có các thanh chắn an toàn trên cửa sổ và cửa cầu thang không? *Safety guards on window and gates for stairs in multi-level home?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
7	Nhà quý vị có các dụng cụ chùi rửa, thuốc men và bao diêm có cất trong tủ khóa không? *Cleaning supplies, medicines and matches are locked away?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
8	Nhà quý vị có số điện thoại của Trung Tâm Kiểm Soát Chất Độc (800-222-1222) được dán gần máy điện thoại không? *Home has phone # of the Poison Control Center posted by phone?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
9	Quý vị có luôn đặt con nằm ngửa để ngủ không? *Always puts baby to sleep on her/his back?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	

10	Quý vị có luôn ở bên cạnh khi con ở trong bồn tắm không? *Always stays with baby in the bathtub?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
11	Quý vị có luôn đặt con trong ghế xe quay ra phía sau ở hàng ghế sau không? *Always places baby in a rear facing car seat in the back seat?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
12	Quý vị có sử dụng ghế xe đúng với tuổi và kích thước của con không? *Car seat used is correct size for age and size of baby?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
13	Con của quý vị có ở hoặc chơi trong nhà có cất giữ súng không? *Baby spends time in home where a gun is kept?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
14	Quý vị có đưa cho con chai chứa bất kỳ thứ gì ngoại trừ sữa nhân tạo, sữa mẹ, hoặc nước không? *Gives baby a bottle with anything in it except formula, breast milk, or water?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Dental Health
15	Con quý vị có ở hay chơi cùng bất kỳ người hút thuốc nào không? *Baby spends time with anyone who smokes?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Tobacco Exposure
16	Quý vị có bất kỳ thắc mắc hoặc lo lắng nào khác về sức khỏe, sự phát triển hay hành vi của con quý vị không? *Any other questions or concerns about baby's health, development or behavior?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Other Questions

Nếu có, vui lòng mô tả:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

7 – 12 Months

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ 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:
					Nutrition
1	Do you breastfeed your baby?	Yes	No	Skip	
2	Does your baby drink or eat 3 servings of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
					Physical Activity
3	Are you concerned about your baby's weight?	No	Yes	Skip	
4	Does your baby watch any TV?	No	Yes	Skip	
					Safety
5	Does your home have a working smoke detector?	Yes	No	Skip	
6	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
7	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
8	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
10	Do you always put your baby to sleep on her/his back?	Yes	No	Skip	

11	Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Skip	
12	Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Skip	
13	Is the car seat you use the right one for the age and size of your baby?	Yes	No	Skip	
14	Does your baby spend time near a swimming pool, river, or lake?	No	Yes	Skip	
15	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
16	Do you give your baby a bottle with anything except formula, breast milk, or water?	No	Yes	Skip	Dental Health
17	Does your baby spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
18	Do you have any other questions or concerns about your baby's health, development or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

Evaluación de Salud

(Staying Healthy Assessment)

7 – 12 meses *(7 – 12 Months)*

Nombre del niño (nombre y apellido)	Fecha de nacimiento	☐ mujer ☐ hombre	Fecha de hoy	¿Asiste a una guardería? ☐ Sí ☐ No
Persona que llena el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			¿Necesita ayuda para llenar el formulario? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda.
Encierre en un círculo la palabra "Omitir" si no sabe una respuesta o no desea responder.
Asegúrese de hablar con el médico si tiene preguntas sobre cualquier sección de este formulario.
Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only
1	¿Amamanta a su bebé? *Breastfeeds baby?*	Sí *Yes*	No	Omitir *Skip*	Nutrition
2	¿Su bebé bebe o come 3 porciones al día de alimentos ricos en calcio, como fórmula, leche materna, queso, yogur, leche de soja o tofu? *Baby drinks/eats 3 servings of calcium rich foods daily?*	Sí *Yes*	No	Omitir *Skip*	
3	¿Le preocupa el peso de su bebé? *Concerned about baby's weight?*	No	Sí *Yes*	Omitir *Skip*	Physical Activity
4	¿Su bebé ve televisión? *Baby watches any TV?*	No	Sí *Yes*	Omitir *Skip*	
5	En su hogar, ¿hay un detector de humo que funcione? *Home has working smoke detector?*	Sí *Yes*	No	Omitir *Skip*	Safety
6	¿Ha cambiado la temperatura del agua a tibia (menos de 120 grados)? *Water temperature turned down to low-warm?*	Sí *Yes*	No	Omitir *Skip*	
7	Si en su hogar hay más de un piso, ¿tiene protección de seguridad en las ventanas y accesos a las escaleras? *Safety guards on windows and gates for stairs in multi-level home?*	Sí *Yes*	No	Omitir *Skip*	
8	En su hogar, ¿los artículos de limpieza, medicamentos y fósforos están en un lugar cerrado con llave? *Cleaning supplies, medicines, and matches locked away?*	Sí *Yes*	No	Omitir *Skip*	
9	En su hogar, ¿está pegado cerca del teléfono el número del Centro de control de intoxicaciones (800-222-1222)? *Home has phone # of Poison Control Center posted by phone?*	Sí *Yes*	No	Omitir *Skip*	

10	¿Siempre acuesta a su bebé boca arriba para dormir? *Always puts baby to sleep on her/his back?*	Sí *Yes*	No	Omitir *Skip*	
11	Cuando su bebé está en la tina, ¿permanece con él en todo momento? *Always stays with baby when in the bathtub?*	Sí *Yes*	No	Omitir *Skip*	
12	¿Su bebé siempre viaja en un asiento de seguridad para automóvil orientado hacia atrás, en el asiento de atrás? *Always places baby in a rear facing car seat in the back seat?*	Sí *Yes*	No	Omitir *Skip*	
13	¿El asiento de seguridad para automóvil que utiliza es el adecuado para la edad y el tamaño de su bebé? *Car seat used is correct size for age and size of baby?*	Sí *Yes*	No	Omitir *Skip*	
14	¿Su bebé pasa tiempo cerca de una piscina, río o lago? *Baby spends time near a swimming pool, river, or lake?*	No	Sí *Yes*	Omitir *Skip*	
15	¿Su bebé pasa tiempo en un hogar donde hay un arma de fuego? *Baby spends time in a home where a gun is kept?*	No	Sí *Yes*	Omitir *Skip*	
16	En el biberón de su bebé, ¿coloca algo que no sea fórmula, leche materna o agua? *Gives baby a bottle with anything in it except formula, breast milk, or water?*	No	Sí *Yes*	Omitir *Skip*	Dental Health
17	¿Su bebé pasa tiempo con alguna persona que fuma? *Baby spends time with anyone who smokes?*	No	Sí *Yes*	Omitir *Skip*	Tobacco Exposure
18	¿Tiene alguna pregunta o inquietud sobre la salud, el desarrollo o la conducta de su bebé? *Any other questions or concerns about baby's health, development, or behavior?*	No	Sí *Yes*	Omitir *Skip*	Other Questions

Si la respuesta es afirmativa, describa, por favor:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

保持健康評估

(Staying Healthy Assessment)

7到12個月 *(7 –12 Months)*

孩童姓名（名和姓）	出生日期	☐女 ☐男	當日日期	在托兒所嗎? ☐是 ☐否
填表人	☐父母 ☐親屬 ☐朋友 ☐監護人 ☐其他（請註明）			需要幫助填寫本表格嗎？ ☐是 ☐否

請儘量回答本表格所有的問題。如果您不知道答案或不想回答，請圈選「跳過」。如果對本表格有任何問題，請一定要問醫生。您的回答將與您的醫療記錄一同受到保護。

需要翻譯員嗎？ ☐是 ☐否

					Clinic Use Only:
1	您用母乳哺育您的寶寶嗎？ *Breastfeeds baby?*	是 *Yes*	否 *No*	跳過 *Skip*	Nutrition
2	您寶寶有沒有每天喝或吃3份高鈣食品，例如嬰兒奶、母乳、乳酪、優格乳、豆漿或豆腐？ *Baby drinks/eats 3 serving of calcium rich foods daily?*	是 *Yes*	否 *No*	跳過 *Skip*	
3	您擔心寶寶的體重嗎？ *Concerned about baby's weight?*	否 *No*	是 *Yes*	跳過 *Skip*	Physical Activity
4	您的寶寶看電視嗎？ *Baby watches any TV?*	否 *No*	是 *Yes*	跳過 *Skip*	
5	您家裡有功能正常的煙霧偵測器嗎？ *Home has working smoke detector?*	是 *Yes*	否 *No*	跳過 *Skip*	Safety
6	您有沒有將水溫調到低溫（低於120度）？ *Water temperature turned down to low-warm?*	是 *Yes*	否 *No*	跳過 *Skip*	
7	如您家是樓房，您有在窗戶和樓梯入口裝置安全防護 ？ *Safety guards on windows and gates for stairs in multi-level home?*	是 *Yes*	否 *No*	跳過 *Skip*	
8	您有將家裡的清潔用品、藥物和火柴鎖起來嗎？ *Cleaning supplies, medicines, and matches locked away?*	是 *Yes*	否 *No*	跳過 *Skip*	
9	您家裡電話旁邊貼著毒物控制中心（800-222-1222）的電話號碼嗎？ *Home has phone # of Poison Control Center posted by phone?*	是 *Yes*	否 *No*	跳過 *Skip*	
10	您是否總是讓寶寶仰躺著睡覺？ *Always puts baby to sleep on her/his back?*	是 *Yes*	否 *No*	跳過 *Skip*	

11	寶寶洗盆浴時您是否一直在她/他身邊？ *Always stays with baby when in the bathtub?*	是 *Yes*	否 *No*	跳過 *Skip*	
12	您是否總是將寶寶放置在車後座後向的安全座椅上？ *Always places baby in a rear facing car seat in the back seat?*	是 *Yes*	否 *No*	跳過 *Skip*	
13	您所使用的安全座椅是否適用於您寶寶的年齡和大小？ *Car seat used is correct size for age and size of baby?*	是 *Yes*	否 *No*	跳過 *Skip*	
14	您寶寶是否會在游泳池附近、河邊或湖邊待一段時間？ *Baby spends time near a swimming pool, river, or lake?*	否 *No*	是 *Yes*	跳過 *Skip*	
15	您寶寶會待在有槍枝的家中嗎？ *Baby spends time in a home where a gun is kept?*	否 *No*	是 *Yes*	跳過 *Skip*	
16	您是否在奶瓶中放嬰兒奶、母乳或水以外的東西餵給您寶寶喝？ *Gives baby a bottle with anything in it except formula, breast milk, or water?*	否 *No*	是 *Yes*	跳過 *Skip*	Dental Health
17	您寶寶是否有時與抽煙的人在一起？ *Baby spends time with anyone who smokes?*	否 *No*	是 *Yes*	跳過 *Skip*	Tobacco Exposure
18	您是否有任何其他關於您寶寶健康、發育或行為上的問題或疑慮？ *Any other questions or concerns about baby's health, development, or behavior?*	否 *No*	是 *Yes*	跳過 *Skip*	Other Questions

若回答是，請描述：

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature: Print Name: Date:

Đánh Giá về Giữ Gìn Sức Khỏe

(Staying Healthy Assessment)

7 – 12 Tháng *(7 –12 Months)*

Tên của Trẻ (tên & họ)	Ngày Sinh	☐ Nữ ☐ Nam	Hôm Nay là Ngày	Có tham gia Dịch Vụ Chăm Sóc Trẻ Em/Ban Ngày không? ☐ Có ☐ Không
Người Điền Mẫu	☐ Phụ Huynh ☐ Họ Hàng ☐ Bạn Bè ☐ Người Giám Hộ ☐ Người Khác (Ghi Rõ)			Cần Hỗ Trợ Điền Mẫu? ☐ Có ☐ Không

Vui lòng trả lời tất cả các câu hỏi trong mẫu này một cách tốt nhất có thể. Khoanh tròn "Bỏ Qua" nếu quý vị không biết câu trả lời hoặc không muốn trả lời. Hãy đảm bảo rằng quý vị sẽ hỏi bác sỹ nếu có thắc mắc liên quan đến bất kỳ điều gì trong mẫu này. Tất cả câu trả lời của quý vị sẽ được bảo vệ như một phần hồ sơ y tế của quý vị.

Cần Phiên Dịch? ☐ Có ☐ Không

					Clinic Use Only:
					Nutrition
1	Quý vị có cho con bú sữa mẹ không? *Breastfeeds baby?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
2	Con của quý vị mỗi ngày có ăn hoặc uống 3 phần thực phẩm giàu canxi như sữa bột theo công thức, sữa mẹ, pho mát, sữa chua, sữa đậu nành hoặc đậu phụ không? *Baby drinks/eats 3 serving of calcium rich foods daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
					Physical Activity
3	Quý vị có lo lắng về cân nặng của con không? *Concerned about baby's weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
4	Con của quý vị có xem TV không? *Baby watches any TV?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
					Safety
5	Nhà quý vị có thiết bị báo khói đang hoạt động không? *Home has working smoke detector?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
6	Quý vị đã đặt nhiệt độ nước xuống mức ấm (dưới 120 độ) chưa? *Water temperature turned down to low-warm?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
7	Nếu nhà quý vị có nhiều hơn một tầng, quý vị có các thanh chắn an toàn trên cửa sổ và cửa cầu thang không? *Safety guards on windows and gates for stairs in multi-level home?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
8	Nhà quý vị có các dụng cụ chùi rửa, thuốc men và bao diêm có cất trong tủ khóa không? *Cleaning supplies, medicines, and matches locked away?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
9	Nhà quý vị có số điện thoại của Trung Tâm Kiểm Soát Chất Độc (800-222-1222) được dán gần máy điện thoại không? *Home has phone # of Poison Control Center posted by phone?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	

10	Quý vị có luôn đặt con nằm ngửa để ngủ không? *Always puts baby to sleep on her/his back?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
11	Quý vị có luôn ở bên cạnh khi con ở trong bồn tắm không? *Always stays with baby when in the bathtub?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
12	Quý vị có luôn đặt con trong ghế xe quay ra phía sau ở hàng ghế sau không? *Always places baby in a rear facing car seat in the back seat?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
13	Quý vị có sử dụng ghế xe đúng với tuổi và kích thước của con không? *Car seat used is the correct size for age and size of baby?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
14	Con quý vị có ở hay chơi gần bể bơi, sông hay hồ không? *Baby spends time near a swimming pool, river, or lake?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
15	Con của quý vị có ở hoặc chơi trong nhà có cất giữ súng không? *Baby spends time in a home where a gun is kept?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
16	Quý vị có đưa cho con chai chứa bất kỳ thứ gì ngoại trừ sữa nhân tạo, sữa mẹ, hoặc nước không? *Gives baby a bottle with anything in it except formula, breast milk, or water?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Dental Health
17	Con quý vị có ở hay chơi cùng bất kỳ người hút thuốc nào không? *Baby spends time with anyone who smokes?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Tobacco Exposure
18	Quý vị có bất kỳ thắc mắc hoặc lo lắng nào khác về sức khỏe, sự phát triển hay hành vi của con quý vị không? *Any other questions or concerns about baby's health, development, or behavior?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Other Questions

Nếu có, vui lòng mô tả:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

1 –2 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ 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 breastfeed your child?	Yes	No	Skip	Nutrition
2	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
3	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
4	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
5	Does your child drink more than one small cup (4 – 6 oz.) of juice per day?	No	Yes	Skip	
6	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
7	Does your child play actively most days of the week?	Yes	No	Skip	Physical Activity
8	Are you concerned about your child's weight?	No	Yes	Skip	
9	Does your child watch TV or play video games?	No	Yes	Skip	
10	Does your home have a working smoke detector?	Yes	No	Skip	Safety
11	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
12	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
13	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
14	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	

15	Do you always stay with your child when she/he is in the bathtub?	Yes	No	Skip	
16	Do you always place your child in a rear facing car seat in the back seat?	Yes	No	Skip	
17	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
18	Do you always check for children before backing your car out?	Yes	No	Skip	
19	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
20	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
21	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
24	Do you have any other questions or concerns about your child's health, development or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:

Evaluación de Salud

(Staying Healthy Assessment)

1 – 2 años *(1 – 2 Years)*

Nombre del niño (nombre y apellido)	Fecha de nacimiento	☐ mujer ☐ hombre	Fecha de hoy	¿Asiste a una guardería? ☐ Sí ☐ No
Persona que llena el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			¿Necesita ayuda para llenar el formulario? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no sabe una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre cualquier sección de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only:
1	¿Amamanta a su hijo? *Breastfeeds child?*	Sí *Yes*	No	Omitir *Skip*	Nutrition
2	¿Su hijo bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *Child drinks/eats 3 servings of calcium rich foods daily?*	Sí *Yes*	No	Omitir *Skip*	
3	¿Su hijo come frutas y verduras, al menos, 2 veces al día? *Child eats fruits and vegetables at least 2 times per day?*	Sí *Yes*	No	Omitir *Skip*	
4	¿Su hijo come alimentos con alto contenido de grasa, como alimentos fritos, papitas, helado o pizza más de una vez por semana? *Child eats high fat foods more than once per week?*	No	Sí *Yes*	Omitir *Skip*	
5	¿Su hijo bebe más de una pequeña taza (4 - 6 oz.) de jugo al día? *Child drinks more than one small cup of juice per day?*	No	Sí *Yes*	Omitir *Skip*	
6	¿Su hijo toma refresco, jugos, bebidas deportivas, bebidas energizantes u otras bebidas endulzadas más de una vez por semana? *Child drinks soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?*	No	Sí *Yes*	Omitir *Skip*	
7	¿Su hijo juega activamente la mayoría de los días de la semana? *Child plays actively most days of the week?*	Sí *Yes*	No	Omitir *Skip*	Physical Activity
8	¿Le preocupa el peso de su hijo? *Concerned about child's weight?*	No	Sí *Yes*	Omitir *Skip*	
9	¿Su hijo ve televisión o juega juegos de video? *Child watches TV or plays video games?*	No	Sí *Yes*	Omitir *Skip*	
10	En su hogar, ¿hay un detector de humo que funcione? *Home has working smoke detector?*	Sí *Yes*	No	Omitir *Skip*	Safety
11	¿Ha cambiado la temperatura del agua a tibia (menos de 120 grados)? *Water temperature turned down to low-warm?*	Sí *Yes*	No	Omitir *Skip*	
12	Si en su hogar hay más de un piso, ¿tiene protección de seguridad en las ventanas y accesos a las escaleras? *Safety guards on windows and gates for stairs in multi-level home?*	Sí *Yes*	No	Omitir *Skip*	
13	En su hogar, ¿los materiales de limpieza, medicamentos y fósforos están en un lugar cerrado con llave? *Cleaning supplies, medicines, and matches locked away?*	Sí *Yes*	No	Omitir *Skip*	

14	En su hogar, ¿está pegado cerca del teléfono el número del Centro de control de intoxicaciones (800-222-1222)? *Home has phone # of Poison Control Center posted by phone?*	Sí *Yes*	No	Omitir *Skip*	
15	Cuando su hijo está en la tina, ¿permanece usted con él en todo momento? *Always stays with child when in the bathtub?*	Sí *Yes*	No	Omitir *Skip*	
16	¿Su hijo siempre viaja en un asiento de seguridad para automóvil orientado hacia atrás, en el asiento de atrás? *Always places child in a rear facing car seat in the back seat?*	Sí *Yes*	No	Omitir *Skip*	
17	¿El asiento de seguridad para automóvil que utiliza es el adecuado para la edad y el tamaño de su hijo? *Car seat used is correct size for age and size of child?*	Sí *Yes*	No	Omitir *Skip*	
18	¿Se fija usted siempre que no haya niños al retroceder en el automóvil al salir de su cochera? *Always checks for children before backing car out?*	Sí *Yes*	No	Omitir *Skip*	
19	¿Su hijo pasa tiempo cerca de una piscina, río o lago? *Child spends time near a swimming pool, river, or lake?*	No	Sí *Yes*	Omitir *Skip*	
20	¿Su hijo pasa tiempo en un hogar donde hay un arma de fuego? *Child spends time in home where a gun is kept?*	No	Sí *Yes*	Omitir *Skip*	
21	¿Su hijo siempre usa casco al montar en bicicleta, patineta o *scooter*? *Child always wears a helmet when riding a bike, skateboard, or scooter?*	Sí *Yes*	No	Omitir *Skip*	
22	¿Su hijo se cepilla los dientes y los limpia con hilo dental todos los días? *Child is helped to brush and floss teeth daily?*	Sí *Yes*	No	Omitir *Skip*	Dental Health
23	¿Su hijo pasa tiempo con alguna persona que fuma? *Child spends time with anyone who smokes?*	No	Sí *Yes*	Omitir *Skip*	Tobacco Exposure
24	¿Tiene alguna otra pregunta o inquietud sobre la salud, el desarrollo o la conducta de su hijo? *Any other questions or concerns about child's health, development, or behavior?*	No	Sí *Yes*	Omitir *Skip*	Other Questions

Si la respuesta es afirmativa, describa, por favor:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:

保持健康評估

(Staying Healthy Assessment)

1到2歲 *(1 – 2 Years)*

孩童姓名（名和姓）	出生日期	☐女 ☐男	當日日期：	在托兒所嗎? ☐是 ☐否
填表人	☐父母 ☐親屬 ☐朋友 ☐監護人 ☐其他（請註明）			需要幫助填寫本表格嗎？ ☐是 ☐否

請儘量回答本表格所有的問題。如果您不知道答案或不想回答，請圈選「跳過」。如果對本表格有任何問題，請一定要問醫生。您的回答將與您的醫療記錄一同受到保護。

需要翻譯員嗎？ ☐是 ☐否

					Clinic Use Only:
1	您用母乳哺育您的小孩嗎？ *Breastfeeds child?*	是 *Yes*	否 *No*	跳過 *Skip*	Nutrition
2	您小孩有沒有每天喝或吃3份高鈣食品，例如牛奶、乳酪、優格乳或豆腐？ *Child drinks/eats 3 servings of calcium rich foods daily?*	是 *Yes*	否 *No*	跳過 *Skip*	
3	您小孩是否每天至少吃兩次蔬菜水果？ *Child eats fruits and vegetables at least 2 times per day?*	是 *Yes*	否 *No*	跳過 *Skip*	
4	您小孩是否一星期超過一次吃高脂食品，如油炸食物、洋芋片、冰淇淋或披薩？ *Child eats high fat foods more than once per week?*	否 *No*	是 *Yes*	跳過 *Skip*	
5	您小孩是否每天喝超過一小杯的（4-6盎斯）果汁？ *Child drinks more than one small cup of juice per day?*	否 *No*	是 *Yes*	跳過 *Skip*	
6	您小孩是否一週喝超過一次蘇打飲料、果汁飲料、運動/能量飲料或其他添加糖份飲料？ *Child drinks soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?*	否 *No*	是 *Yes*	跳過 *Skip*	
7	您小孩有沒有每週多日活躍地玩？ *Child plays actively most days of the week?*	是 *Yes*	否 *No*	跳過 *Skip*	Physical Activity
8	您擔心您小孩的體重嗎？ *Concerned about child's weight?*	否 *No*	是 *Yes*	跳過 *Skip*	
9	您小孩有沒有看電視或玩電動遊戲？ *Child watches TV or plays video games?*	否 *No*	是 *Yes*	跳過 *Skip*	
10	您家裡有功能正常的煙霧偵測器嗎？ *Home has working smoke detector?*	是 *Yes*	否 *No*	跳過 *Skip*	Safety
11	您有沒有將水溫調到低溫（低於120度）？ *Water temperature turned down to low-warm?*	是 *Yes*	否 *No*	跳過 *Skip*	
12	如您家是樓房，您有在窗戶和樓梯入口裝置安全防護嗎？ *Safety guards on windows and gates for stairs in multi-level home?*	是 *Yes*	否 *No*	跳過 *Skip*	
13	您有將家裡的清潔用品、藥物和火柴鎖起來嗎？ *Cleaning supplies, medicines, and matches locked away?*	是 *Yes*	否 *No*	跳過 *Skip*	

14	您家裡電話旁邊貼著毒物控制中心（800-222-1222）的電話號碼嗎？ *Home has phone # of Poison Control Center posted by phone?*	是 *Yes*	否 *No*	跳過 *Skip*	
15	您小孩洗盆浴時您是否一直在她/他身邊？ *Always stays with child when in the bathtub?*	是 *Yes*	否 *No*	跳過 *Skip*	
16	您是否總是將小孩放置在車後座後向的安全座椅上？ *Always places child in a rear facing car seat in the back seat?*	是 *Yes*	否 *No*	跳過 *Skip*	
17	您所使用的安全座椅是否適用於您小孩的年齡和大小？ *Car seat used is correct size for age and size of child?*	是 *Yes*	否 *No*	跳過 *Skip*	
18	在倒車前您是否總是先檢查您的小孩? *Always checks for children before backing car out?*	是 *Yes*	否 *No*	跳過 *Skip*	
19	您小孩是否會在游泳池附近、河邊或湖邊待一段時間？ *Child spends time near a swimming pool, river, or lake?*	否 *No*	是 *Yes*	跳過 *Skip*	
20	您小孩會待在有槍枝的家中嗎？ *Child spends time in home where a gun is kept?*	否 *No*	是 *Yes*	跳過 *Skip*	
21	您孩子騎自行車、玩滑板或滑板車時是否總是戴安全帽？ *Child always wears a helmet when riding a bike, skateboard, or scooter?*	是 *Yes*	否 *No*	跳過 *Skip*	
22	您孩子每天都有刷牙和使用牙線嗎？ *Child is helped to brush and floss teeth daily?*	是 *Yes*	否 *No*	跳過 *Skip*	Dental Health
23	您孩子是否有時與抽煙的人在一起？ *Child spends time with anyone who smokes?*	否 *No*	是 *Yes*	跳過 *Skip*	Tobacco Exposure
24	您是否有任何其他關於您小孩健康、發育或行為上的問題或疑慮？ *Any other questions or concerns about child's health, development or behavior?*	否 *No*	是 *Yes*	跳過 *Skip*	Other Questions

若回答是，請描述：

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:

Đánh Giá về Giữ Gìn Sức Khỏe

(Staying Healthy Assessment)

1 –2 Tuổi *(1 – 2 Years)*

Tên của Trẻ (tên & họ)	Ngày Sinh	☐ Nữ ☐ Nam	Hôm Nay là Ngày	Có tham gia Dịch Vụ Chăm Sóc Trẻ Em/Ban Ngày không? ☐ Có ☐ Không
Người Điền Mẫu	☐ Phụ Huynh ☐ Họ Hàng ☐ Bạn Bè ☐ Người Giám Hộ ☐ Người Khác (Ghi Rõ)			Cần Hỗ Trợ Điền Mẫu? ☐ Có ☐ Không

Vui lòng trả lời tất cả các câu hỏi trong mẫu này một cách tốt nhất có thể. Khoanh tròn "Bỏ Qua" nếu quý vị không biết câu trả lời hoặc không muốn trả lời. Hãy đảm bảo rằng quý vị sẽ hỏi bác sỹ nếu có thắc mắc liên quan đến bất kỳ điều gì trong mẫu này. Tất cả câu trả lời của quý vị sẽ được bảo vệ như một phần hồ sơ y tế của quý vị.

Cần Phiên Dịch? ☐ Có ☐ Không

Clinic Use Only:

					Nutrition
1	Quý vị có cho con bú sữa mẹ không? *Breastfeeds child?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
2	Con của quý vị mỗi ngày có ăn hoặc uống 3 phần thực phẩm giàu canxi như sữa, pho mát, sữa chua, sữa đậu nành hoặc đậu phụ không? *Child drinks/eats 3 servings of calcium rich foods daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
3	Con quý vị có ăn trái cây và rau ít nhất hai lần mỗi ngày không? *Child eats fruits and vegetables at least 2 times per day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
4	Con của quý vị có ăn các thực phẩm nhiều chất béo như thực phẩm chiên rán, khoai tây chiên, kem, pizza nhiều hơn một lần mỗi tuần không? *Child eats high fat foods more than once per week?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
5	Con của quý vị có uống nhiều hơn một cốc nhỏ (4 – 6 ao-xơ.) nước hoa quả mỗi ngày không? *Child drinks more than one small cup of juice per day?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
6	Con của quý vị có uống nước xô-đa, nước hoa quả, đồ uống thể thao, nước tăng lực, hoặc đồ uống có đường khác nhiều hơn một lần mỗi tuần không? *Child drinks soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
					Physical Activity
7	Con của quý vị có chơi đùa tích cực hầu hết các ngày trong tuần không? *Child plays actively most days of the week?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
8	Quý vị có lo lắng về cân nặng của con không? *Concerned about child's weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	

9	Con của quý vị có xem TV hoặc chơi các trò chơi điện tử video không? *Child watches TV or plays video games?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
10	Nhà quý vị có thiết bị báo khói đang hoạt động không? *Home has working smoke detector?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Safety
11	Quý vị đã đặt nhiệt độ nước xuống mức ấm (dưới 120 độ) chưa? *Water temperature turned down to low-warm?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
12	Nếu nhà quý vị có nhiều hơn một tầng, quý vị có các thanh chắn an toàn trên cửa sổ và cửa cầu thang không? *Safety guards on windows and gates for stairs in multi-level home?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
13	Nhà quý vị có các dụng cụ chùi rửa, thuốc men và bao diêm cất trong tủ khóa không? *Cleaning supplies, medicines, and matches locked away?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
14	Nhà quý vị có số điện thoại của Trung Tâm Kiểm Soát Chất Độc (800-222-1222) được dán gần máy điện thoại không? *Home has phone # of Poison Control Center posted by phone?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
15	Quý vị có luôn ở bên cạnh khi con ở trong bồn tắm không? *Always stays with child when in the bathtub?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
16	Quý vị có luôn đặt con trong ghế xe quay về phía sau ở hàng ghế sau không? *Always places child in a rear facing car seat in the back seat?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
17	Quý vị có sử dụng ghế xe đúng với tuổi và kích thước của con không? *Car seat used is correct size for age and size of child?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
18	Quý vị có luôn kiểm tra xem có trẻ em ở gần xe trước khi lùi xe ra không? *Always checks for children before backing car out?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
19	Con của quý vị có ở hay chơi gần bể bơi, sông hay hồ không? *Child spends time near a swimming pool, river, or lake?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
20	Con quý vị có ở hoặc chơi ở nhà có cất giữ súng không? *Child spends time in home where a gun is kept?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	

21	Con quý vị có luôn đội mũ bảo hiểm khi đi xe đạp, trượt ván hay đi xe trượt scooter không? *Child always wears a helmet when riding a bike, skate board, or scooter?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
22	Quý vị có giúp con đánh răng và làm sạch kẽ răng mỗi ngày không? *Child is helped to brush and floss teeth daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Dental Health
23	Con quý vị có ở hay chơi cùng bất kỳ người hút thuốc nào không? *Child spends time with anyone who smokes?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Tobacco Exposure
24	Quý vị có bất kỳ thắc mắc hoặc lo lắng nào khác về sức khỏe, sự phát triển hay hành vi của con quý vị không? *Any other questions or concerns about child's health, development or behavior?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Other Questions

Nếu có, vui lòng mô tả:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **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:

Staying Healthy Assessment

3 – 4 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ 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	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one small cup (4 – 6 oz. cup) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
6	Does your child play actively most days of the week?	Yes	No	Skip	Physical Activity
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
9	Does your home have a working smoke detector?	Yes	No	Skip	Safety
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
11	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
12	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
13	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
14	Do you always stay with your child when she/he is in the bathtub?	Yes	No	Skip	

15	Do you always place your child in a forward facing car seat in the back seat?	Yes	No	Skip	
16	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
17	Do you always check for children before backing your car out?	Yes	No	Skip	
18	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
19	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
20	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
21	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
24	Do you have any other questions or concerns about your child's development, health or behavior?	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	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

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:

Evaluación de Salud

(Staying Healthy Assessment)

3 – 4 años *(3 –4 Years)*

Nombre del niño (nombre y apellido)	Fecha de nacimiento	☐ mujer ☐ hombre	Fecha de hoy	¿Asiste a una guardería? ☐ Sí ☐ No
Persona que llena el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			¿Necesita ayuda para llenar el formulario? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no sabe una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre alguna sección de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only:
1	¿Su hijo bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *Child drinks/eats 3 servings of calcium rich foods daily?*	Sí *Yes*	No	Omitir *Skip*	Nutrition
2	¿Su hijo come frutas y verduras, al menos, 2 veces al día? *Child eats fruits and vegetables at least 2 times per day?*	Sí *Yes*	No	Omitir *Skip*	
3	¿Su hijo come alimentos con alto contenido de grasa, como alimentos fritos, papitas, helado o pizza más de una vez por semana? *Child eats high fat foods more than once per week?*	No	Sí *Yes*	Omitir *Skip*	
4	¿Su hijo bebe más de una taza pequeña (taza de 4 a 6 oz.) de jugo al día? *Child drinks more than one small cup of juice per day?*	No	Sí *Yes*	Omitir *Skip*	
5	¿Su hijo toma refresco, jugos, bebidas deportivas, bebidas energizantes u otras bebidas endulzadas más de una vez por semana? *Child drinks soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?*	No	Sí *Yes*	Omitir *Skip*	
6	¿Su hijo hace ejercicio o juega deportes la mayoría de los días? *Child plays actively most days of the week?*	Sí *Yes*	No	Omitir *Skip*	Physical Activity
7	¿Le preocupa el peso de su hijo? *Concerned about child's weight?*	No	Sí *Yes*	Omitir *Skip*	
8	¿Su hijo ve televisión o juega juegos de video menos de 2 horas al día? *Child watches TV or plays video games less than 2 hours per day?*	Sí *Yes*	No	Omitir *Skip*	
9	En su hogar, ¿hay un detector de humo que funcione? *Home has a working smoke detector?*	Sí *Yes*	No	Omitir *Skip*	Safety
10	¿Ha cambiado la temperatura del agua a tibia (menos de 120 grados)? *Water temperature turned down to low-warm?*	Sí *Yes*	No	Omitir *Skip*	
11	Si en su hogar hay más de un piso, ¿tiene protección de seguridad en las ventanas y accesos a las escaleras? *Safety guards on windows and gates for stairs in multi-level home?*	Sí *Yes*	No	Omitir *Skip*	
12	En su hogar, ¿los materiales de limpieza, medicamentos y fósforos están en un lugar cerrado con llave? *Cleaning supplies, medicines, and matches locked away?*	Sí *Yes*	No	Omitir *Skip*	
13	En su hogar, ¿está pegado cerca del teléfono el número del Centro de control de intoxicaciones (800-222-1222)? *Home has phone # of the Poison Control Center posted by phone?*	Sí *Yes*	No	Omitir *Skip*	

14	Cuando su hijo está en la tina, ¿permanece con él en todo momento? *Always stays with child when in the bathtub?*	Sí *Yes*	No	Omitir *Skip*	
15	¿Su hijo siempre viaja en un asiento de seguridad para automóvil orientado hacia delante, en el asiento de atrás? *Always places child in a forward facing car seat in the back seat?*	Sí *Yes*	No	Omitir *Skip*	
16	¿El asiento de seguridad para automóvil que utiliza es el adecuado para la edad y el tamaño de su hijo? *Car seat used is correct size for age and size of child?*	Sí *Yes*	No	Omitir *Skip*	
17	¿Se fija usted siempre que no haya niños al retroceder en el automóvil al salir de su cochera? *Always checks for children before backing car out?*	Sí *Yes*	No	Omitir *Skip*	
18	¿Su hijo pasa tiempo cerca de una piscina, río o lago? *Child spends time near a swimming pool, river, or lake?*	No	Sí *Yes*	Omitir *Skip*	
19	¿Su hijo pasa tiempo en un hogar donde hay un arma de fuego? *Child spends time in home where a gun is kept?*	No	Sí *Yes*	Omitir *Skip*	
20	¿Su hijo siempre usa casco al montar en bicicleta, patineta o *scooter*? *Child always wears a helmet when riding a bike, skateboard, or scooter?*	Sí *Yes*	No	Omitir *Skip*	
21	¿Su hijo ha presenciado o ha sido víctima de abuso o violencia? *Child ever witnessed or been victim of abuse or violence?*	No	Sí *Yes*	Omitir *Skip*	
22	¿Su hijo se cepilla los dientes y los limpia con hilo dental todos los días? *Child is helped to brush and floss teeth daily?*	Sí *Yes*	No	Omitir *Skip*	Dental Health
23	¿Su bebé pasa tiempo con alguna persona que fuma? *Child spends time with anyone who smokes?*	No	Sí *Yes*	Omitir *Skip*	Tobacco Exposure
24	¿Tiene alguna pregunta o inquietud sobre la salud, el desarrollo o el comportamiento de su bebé? *Any other questions or concerns about child's health or behavior?*	No	Sí *Yes*	Omitir *Skip*	Other Questions

Si la respuesta es afirmativa, describa, por favor:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

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:

保持健康評估

(Staying Healthy Assessment)

3-4歲 *(3 – 4 Years)*

孩童姓名（名和姓）	出生日期	☐女 ☐男	當日日期：	在托兒所嗎? ☐是 ☐否
填表人	☐父母 ☐親屬 ☐朋友 ☐監護人 ☐其他（請註明）			需要幫助填寫本表格嗎？ ☐是 ☐否

請儘量回答本表格所有的問題。如果您不知道答案或不想回答，請圈選「跳過」。如果對本表格有任何問題，請一定要問醫生。您的回答將與您的醫療記錄一同受到保護。

需要翻譯員嗎？ ☐是 ☐否

					Clinic Use Only:
					Nutrition
1	您小孩有沒有每天喝或吃3份高鈣食品，例如牛奶、乳酪、優格乳或豆腐？ *Child drinks/eats 3 servings of calcium rich foods daily?*	是 *Yes*	否 *No*	跳過 *Skip*	
2	您小孩是否每天至少吃兩次蔬菜水果？ *Child eats fruits and vegetables at least 2 times per day?*	是 *Yes*	否 *No*	跳過 *Skip*	
3	您小孩是否一星期超過一次吃高脂食品，如油炸食物、洋芋片、冰淇淋或披薩？ *Child eats high fat foods more than once per week?*	否 *No*	是 *Yes*	跳過 *Skip*	
4	您小孩是否每天喝超過一小杯的（4-6盎斯）果汁？ *Child drinks more than one small cup of juice per day?*	否 *No*	是 *Yes*	跳過 *Skip*	
5	您小孩是否一週喝超過一次蘇打飲料、果汁飲料、運動/能量飲料或其他添加糖份飲料？ *Child drinks soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?*	否 *No*	是 *Yes*	跳過 *Skip*	
6	您小孩有沒有每週多日活躍地玩？ *Child plays actively most days of the week?*	是 *Yes*	否 *No*	跳過 *Skip*	Physical Activity
7	您擔心您小孩的體重嗎？ *Concerned about child's weight?*	否 *No*	是 *Yes*	跳過 *Skip*	
8	您小孩是否每天看少於2小時的電視或玩電動遊戲？ *Child watches TV or plays video games less than 2 hours per day?*	是 *Yes*	否 *No*	跳過 *Skip*	
9	您家裡有功能正常的煙霧偵測器嗎？ *Home has a working smoke detector?*	是 *Yes*	否 *No*	跳過 *Skip*	Safety
10	您有沒有將水溫調到低溫（低於120度）？ *Water temperature turned down to low-warm?*	是 *Yes*	否 *No*	跳過 *Skip*	
11	如您家是樓房，您有在窗戶和樓梯入口裝置安全防護嗎？ *Safety guards on windows and gates for stairs in multi-level home?*	是 *Yes*	否 *No*	跳過 *Skip*	
12	您有將家裡的清潔用品、藥物和火柴鎖起來嗎？ *Cleaning supplies, medicines, and matches locked away?*	是 *Yes*	否 *No*	跳過 *Skip*	
13	您家裡電話旁邊貼著毒物控制中心（800-222-1222）的電話號碼嗎？ *Home has phone # of the Poison Control Center posted by phone?*	是 *Yes*	否 *No*	跳過 *Skip*	

14	您小孩洗盆浴時您是否一直在她/他身邊 *Always stays with child when in the bathtub?*	是 *Yes*	否 *No*	跳過 *Skip*	
15	您是否總是將小孩放置在車後座前向的安全座椅上？ *Always places child in a forward facing car seat in the back seat?*	是 *Yes*	否 *No*	跳過 *Skip*	
16	您所使用的安全座椅是否適用於您小孩的年齡和大小？ *Car seat used is correct size for age and size of child?*	是 *Yes*	否 *No*	跳過 *Skip*	
17	在倒車前您是否總是先檢查您的小孩? *Always checks for children before backing car out?*	是 *Yes*	否 *No*	跳過 *Skip*	
18	您小孩是否會在游泳池附近、河邊或湖邊待一段時間？ *Child spends time near a swimming pool, river, or lake?*	否 *No*	是 *Yes*	跳過 *Skip*	
19	您小孩會待在有槍枝的家中嗎？ *Child spends time in home where a gun is kept?*	否 *No*	是 *Yes*	跳過 *Skip*	
20	您小孩騎自行車、玩滑板或滑板車時是否總是戴安全帽？ *Child always wears a helmet when riding a bike, skateboard, or scooter?*	是 *Yes*	否 *No*	跳過 *Skip*	
21	您小孩是否曾目睹虐待或暴力，或者本身是虐待或暴力受害者？ *Child ever witnessed or been victim of abuse or violence?*	否 *No*	是 *Yes*	跳過 *Skip*	
22	您小孩每天都有刷牙和使用牙線嗎？ *Child is helped to brush and floss teeth daily?*	是 *Yes*	否 *No*	跳過 *Skip*	Dental Health
23	您小孩是否有時與抽煙的人在一起？ *Child spends time with anyone who smokes?*	否 *No*	是 *Yes*	跳過 *Skip*	Tobacco Exposure
24	您是否有任何其他關於您小孩健康、發育或行為上的問題或疑慮？ *Any other questions or concerns about child's health or behavior?*	否 *No*	是 *Yes*	跳過 *Skip*	Other Questions

若回答是，請描述：

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

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:

Đánh Giá về Giữ Gìn Sức Khỏe

(Staying Healthy Assessment)

3 – 4 Tuổi *(3 – 4 Years)*

Tên của Trẻ (tên & họ)	Ngày Sinh	☐ Nữ ☐ Nam	Hôm Nay là Ngày	Có tham gia Dịch Vụ Chăm Sóc Trẻ Em/Ban Ngày không? ☐ Có ☐ Không
Người Điền Mẫu	☐ Phụ Huynh ☐ Họ Hàng ☐ Bạn Bè ☐ Người Giám Hộ ☐ Người Khác (Ghi Rõ)			Cần Hỗ Trợ Điền Mẫu? ☐ Có ☐ Không

Vui lòng trả lời tất cả các câu hỏi trong mẫu này một cách tốt nhất có thể. Khoanh tròn "Bỏ Qua" nếu quý vị không biết câu trả lời hoặc không muốn trả lời. Hãy đảm bảo rằng quý vị sẽ hỏi bác sỹ nếu có thắc mắc liên quan đến bất kỳ điều gì trong mẫu này. Tất cả câu trả lời của quý vị sẽ được bảo vệ như một phần hồ sơ y tế của quý vị.

Cần Phiên Dịch? ☐ Có ☐ Không

					Clinic Use Only:
					Nutrition
1	Con của quý vị có ăn hoặc uống 3 phần thực phẩm giàu canxi như sữa, pho mát, sữa chua, sữa đậu nành hoặc đậu phụ mỗi ngày không? *Child drinks/eats 3 servings of calcium rich foods daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
2	Con quý vị có ăn trái cây và rau ít nhất hai lần mỗi ngày không? *Child eats fruits and vegetables at least 2 times per day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
3	Con của quý vị có ăn các thực phẩm nhiều chất béo như thực phẩm chiên rán, khoai tây chiên, kem, bánh pizza nhiều hơn một lần mỗi tuần không? *Child eats high fat foods more than once per week?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
4	Con quý vị có uống nhiều hơn một cốc nhỏ (cốc 4 – 6 ao-xơ) nước hoa quả mỗi ngày không? *Child drinks more than one small cup of juice per day?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
5	Con của quý vị có uống nước xô-đa, nước hoa quả, đồ uống thể thao, nước tăng lực, hoặc đồ uống có đường khác nhiều hơn một lần mỗi tuần không? *Child drinks soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
					Physical Activity
6	Con của quý vị có chơi đùa tích cực hầu hết các ngày trong tuần không? *Child plays actively most days of the week?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
7	Quý vị có lo lắng về cân nặng của con không? *Concerned about your child's weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	

8	Con quý vị có xem TV hoặc chơi trò chơi điện tử video dưới 2 tiếng mỗi ngày không? *Child watches TV or plays video games less than 2 hours per day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
9	Nhà quý vị có thiết bị báo khói đang hoạt động không? *Home has a working smoke detector?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Safety
10	Quý vị đã đặt nhiệt độ nước xuống mức ấm (dưới 120 độ) chưa? *Water temperature turned down to low-warm?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
11	Nếu nhà quý vị có nhiều hơn một tầng, quý vị có các thanh chắn an toàn trên cửa sổ và cửa cầu thang không? *Safety guards on windows and gates for stairs in multi-level home?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
12	Nhà quý vị có các dụng cụ chùi rửa, thuốc men và bao diêm có cất trong tủ khóa không? *Cleaning supplies, medicines, and matches locked away?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
13	Nhà quý vị có số điện thoại của Trung Tâm Kiểm Soát Chất Độc (800-222-1222) được dán gần máy điện thoại không? *Home has phone # of the Poison Control Center posted by phone?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
14	Quý vị có luôn ở bên cạnh khi con ở trong bồn tắm không? *Always stays with child when in the bathtub?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
15	Quý vị có luôn đặt con trong ghế xe hướng về phía trước ở hàng ghế sau không? *Always places child in a forward facing car seat in the back seat?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
16	Quý vị có sử dụng ghế xe đúng với tuổi và kích thước của con không? *Car seat used is correct size for age and size for child?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
17	Quý vị có luôn kiểm tra xem có trẻ em ở gần xe trước khi lùi xe ra không? *Always checks for children before backing car out?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
18	Con của quý vị có ở hay chơi gần bể bơi, sông hay hồ không? *Child spends time near a swimming pool, river, or lake?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	

19	Con quý vị có ở hoặc chơi ở nhà có cất giữ súng không? *Child spends time in home where a gun is kept?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
20	Con quý vị có luôn đội mũ bảo hiểm khi đi xe đạp, trượt ván hay đi xe scooter không? *Child always wears a helmet when riding a bike, skateboard, or scooter?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
21	Con quý vị đã bao giờ chứng kiến hoặc là nạn nhân của hành vi lạm dụng hay bạo lực chưa? *Child ever witnessed or been victim of abuse or violence?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
22	Quý vị có giúp con đánh răng và làm sạch kẽ răng mỗi ngày không? *Child is helped to brush and floss teeth daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Dental Health
23	Con quý vị có ở hay chơi cùng bất kỳ người hút thuốc nào không? *Child spends time with anyone who smokes?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Tobacco Exposure
24	Quý vị có bất kỳ thắc mắc hoặc lo lắng nào khác về sự phát triển, sức khỏe hay hành vi của con quý vị không? *Any other questions or concerns about child's health or behavior?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Other Questions

Nếu có, vui lòng mô tả:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

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:

Staying Healthy Assessment

5 – 8 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School?
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ 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:
	Nutrition				
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one small cup (4 - 6 oz.) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
	Physical Activity				
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
	Safety				
9	Does your home have a working smoke detector?	Yes	No	Skip	
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
11	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
12	Do you always place your child in a booster seat in the back seat (or use a seat belt if your child is over 4'9")?	Yes	No	Skip	
13	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
14	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	

15	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
16	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
17	Has your child ever witnessed or been victim of abuse or violence?	No	Yes	Skip	
18	Has your child been hit or hit someone in the past year?	No	Yes	Skip	
19	Has your child ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
20	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
21	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
22	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
23	Do you have any other questions or concerns about your child's health or behavior?	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	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

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:

Evaluación de Salud

(Staying Healthy Assessment)

5 – 8 años *(5 – 8 Years)*

Nombre del niño (nombre y apellido)	Fecha de nacimiento	☐ mujer ☐ hombre	Fecha de hoy	¿Año escolar?
Persona que llena el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			Asistencia escolar ¿Regular? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no sabe una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre cualquier sección de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only:
					Nutrition
1	¿Su hijo bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *Child drinks/eats 3 servings of calcium-rich foods daily?*	Sí *Yes*	No	Omitir *Skip*	
2	¿Su hijo come frutas y verduras, al menos, 2 veces al día? *Child eats fruits and vegetables at least two times per day?*	Sí *Yes*	No	Omitir *Skip*	
3	¿Su hijo come alimentos con alto contenido de grasa, como alimentos fritos, papitas, helado o pizza más de una vez por semana? *Child eats high fat foods more than once per week?*	No	Sí *Yes*	Omitir *Skip*	
4	¿Su hijo bebe más de una pequeña taza (4 - 6 oz.) de jugo al día? *Child drinks more than one small cup of juice per day?*	No	Sí *Yes*	Omitir *Skip*	
5	¿Su hijo toma refresco, jugos, bebidas deportivas, bebidas energizantes u otras bebidas endulzadas más de una vez por semana? *Child drinks soda, juice/ sports/ energy drinks, or other sweetened drinks more than once per week?*	No	Sí *Yes*	Omitir *Skip*	
					Physical Activity
6	¿Su hijo hace ejercicio o juega deportes la mayoría de los días de la semana? *Child exercises or plays sports most days of the week?*	Sí *Yes*	No	Omitir *Skip*	
7	¿Le preocupa el peso de su hijo? *Concerned about child's weight?*	No	Sí *Yes*	Omitir *Skip*	
8	¿Su hijo ve televisión o juega juegos de video menos de 2 horas al día? *Child watches TV or plays video games less than 2 hours per day?*	Sí *Yes*	No	Omitir *Skip*	
					Safety
9	En su hogar, ¿hay un detector de humo que funcione? *Home has a working smoke detector?*	Sí *Yes*	No	Omitir *Skip*	
10	¿Ha cambiado la temperatura del agua a tibia (menos de 120 grados)? *Water temperature turned down to low-warm?*	Sí *Yes*	No	Omitir *Skip*	
11	En su hogar, ¿está pegado cerca del teléfono el número del Centro de control de intoxicaciones (800-222-1222)? *Home has phone # of the Poison Control Center posted by phone?*	Sí *Yes*	No	Omitir *Skip*	
12	¿Coloca usted siempre a su hijo en un asiento para niños en el en el asiento de atrás (o usa un cinturón de seguridad) si su hijo mide más de 4'9"? *Always places child in booster seat in back seat (or seat belt) if child is over 4'9"?*	Sí *Yes*	No	Omitir *Skip*	
13	¿Su hijo pasa tiempo cerca de una piscina, río o lago? *Child spends time near a swimming pool, river, or lake?*	No	Sí *Yes*	Omitir *Skip*	

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14	¿Su hijo pasa tiempo en un hogar donde hay un arma de fuego? *Child spends time in home where a gun is kept?*	No	Sí *Yes*	Omitir *Skip*	
15	¿Su hijo pasa tiempo con alguna persona que lleve un arma de fuego, un cuchillo u otra arma? *Child spends time with anyone who carries a gun, knife, or other weapon?*	No	Sí *Yes*	Omitir *Skip*	
16	¿Su hijo siempre usa casco al montar en bicicleta, patineta o *scooter*? *Child always wears a helmet when riding a bike, skateboard, or scooter?*	Sí *Yes*	No	Omitir *Skip*	
17	¿Su hijo ha presenciado o ha sido víctima de abuso o violencia? *Has child ever witnessed or been victim of abuse or violence?*	No	Sí *Yes*	Omitir *Skip*	
18	¿A su hijo le ha pegado alguien o le ha pegado él a alguien durante el año pasado? *Has child been hit or hit someone in the past year?*	No	Sí *Yes*	Omitir *Skip*	
19	¿Su hijo ha sido acosado alguna vez o se sintió inseguro en la escuela o en su vecindario (o lo acosaron por Internet)? *Has child ever been bullied or felt unsafe at school/neighborhood (or been cyber-bullied)?*	No	Sí *Yes*	Omitir *Skip*	
20	¿Su hijo se cepilla los dientes y los limpia con hilo dental todos los días? *Child brushes and flosses teeth daily?*	Sí *Yes*	No	Omitir *Skip*	Dental Health
21	¿Su hijo parece a menudo triste o deprimido? *Child often seems sad or depressed?*	No	Sí *Yes*	Omitir *Skip*	Mental Health
22	¿Su hijo pasa tiempo con alguna persona que fuma? *Child spends time with anyone who smokes?*	No	Sí *Yes*	Omitir *Skip*	Tobacco Exposure
23	¿Tiene alguna pregunta o inquietud sobre la salud, el desarrollo o el comportamiento de su bebé? *Any other questions or concerns about child's health or behavior?*	No	Sí *Yes*	Omitir *Skip*	Other Questions

Si la respuesta es afirmativa, describa, por favor:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

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:

保持健康評估

(Staying Healthy Assessment)

5-8歲 *(5 – 8 Years)*

孩童姓名（名和姓）	出生日期	☐女 ☐男	當日日期：	學校年級？
填表人	☐父母 ☐親屬 ☐朋友 ☐監護人 ☐其他（請註明）			學校出席 正常？☐是 ☐否

請儘量回答本表格所有的問題。如果您不知道答案或不想回答，請圈選「跳過」。如果對本表格有任何問題，請一定要問醫生。您的回答將與您的醫療記錄一同受到保護。

需要翻譯員嗎？ ☐是 ☐否

					Clinic Use Only:
1	您小孩有沒有每天喝或吃3份高鈣食品，例如牛奶、乳酪、優格乳、豆漿或豆腐？ *Child drinks/eats 3 servings of calcium-rich foods daily?*	是 *Yes*	否 *No*	跳過 *Skip*	Nutrition
2	您小孩是否每天至少吃兩次蔬菜水果？ *Child eats fruits and vegetables at least two times per day?*	是 *Yes*	否 *No*	跳過 *Skip*	
3	您小孩是否一星期超過一次吃高脂食品，如油炸食物、洋芋片、冰淇淋或披薩？ *Child eats high fat foods more than once per week?*	否 *No*	是 *Yes*	跳過 *Skip*	
4	您小孩是否每天喝超過一小杯的（4-6盎斯）果汁？ *Child drinks more than one small cup of juice per day*	否 *No*	是 *Yes*	跳過 *Skip*	
5	您小孩是否一週喝超過一次蘇打飲料、果汁飲料、運動飲料、能量飲料或其他添加糖份飲料？ *Child drinks soda, juice/sports/energy drinks, or other sweetened drinks more than once per week?*	否 *No*	是 *Yes*	跳過 *Skip*	
6	您小孩有沒有每週多日做運動或參加運動項目？ *Child exercises or plays sports most days of the week?*	是 *Yes*	否 *No*	跳過 *Skip*	Physical Activity
7	您擔心您小孩的體重嗎？ *Concerned about child's weight?*	否 *No*	是 *Yes*	跳過 *Skip*	
8	您小孩是否每天看少於2小時的電視或玩電動遊戲？ *Child watches TV or plays video games less than 2 hours per day?*	是 *Yes*	否 *No*	跳過 *Skip*	
9	您家裡有功能正常的煙霧偵測器嗎？ *Home has a working smoke detector?*	是 *Yes*	否 *No*	跳過 *Skip*	Safety
10	您有沒有將水溫調到低溫（低於120度）？ *Water temperature turned down to low-warm?*	是 *Yes*	否 *No*	跳過 *Skip*	
11	您家裡電話旁邊貼著毒物控制中心（800-222-1222）的電話號碼嗎？ *Home has phone # of the Poison Control Center posted by phone?*	是 *Yes*	否 *No*	跳過 *Skip*	
12	您是否總是放置您小孩在車後座加高座椅上（或如身高高於4’ 9” ，使用安全帶）？ *Always places child in booster seat in back seat (or uses a seat belt) if child is over 4'9"?*	是 *Yes*	否 *No*	跳過 *Skip*	
13	您小孩是否會在游泳池附近、河邊或湖邊待一段時間？ *Child spends time near a swimming pool, river, or lake?*	否 *No*	是 *Yes*	跳過 *Skip*	

14	您小孩會待在有槍枝的家中嗎？ *Child spends time in home where a gun is kept?*	否 *No*	是 *Yes*	跳過 *Skip*	
15	您孩子是否有時與任何攜帶槍、刀或其他武器的人在一起？ *Child spends time with anyone who carries a gun, knife, or other weapon?*	否 *No*	是 *Yes*	跳過 *Skip*	
16	您小孩騎自行車、玩滑板或滑板車時是否總是戴安全帽？ *Child always wears a helmet when riding a bike, skateboard, or scooter?*	是 *Yes*	否 *No*	跳過 *Skip*	
17	您小孩是否曾目睹虐待或暴力，或者本身是虐待或暴力受害者？ *Child ever witnessed or been victim of abuse or violence?*	否 *No*	是 *Yes*	跳過 *Skip*	
18	您孩子在過去的一年是否曾被打或打人？ *Has child been hit or hit someone in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
19	您孩子是否曾在學校或您居家附近被人欺負，或感到不安全（或在網絡被欺負）？ *Has child ever been bullied or felt unsafe at school/neighborhood (or been cyber-bullied?)*	否 *No*	是 *Yes*	跳過 *Skip*	
20	您孩子每天都有刷牙和使用牙線嗎？ *Child brushes and flosses teeth daily?*	是 *Yes*	否 *No*	跳過 *Skip*	Dental Health
21	您的孩子是否經常顯得悲傷或沮喪？ *Child often seems sad or depressed?*	否 *No*	是 *Yes*	跳過 *Skip*	Mental Health
22	您小孩是否有時與抽煙的人在一起？ *Child spends time with anyone who smokes?*	否 *No*	是 *Yes*	跳過 *Skip*	Tobacco Exposure
23	您是否有任何其他關於您小孩健康或行為上的問題或疑慮？ *Any other questions or concerns about child's health or behavior?*	否 *No*	是 *Yes*	跳過 *Skip*	Other Questions

若回答是，請描述：

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

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:

ánh Giá về Giữ Gìn Sức Khỏe

(Staying Healthy Assessment)

5 – 8 Tuổi *(5 – 8 Years)*

Tên của Trẻ (tên & họ)	Ngày Sinh	☐ Nữ ☐ Nam	Hôm Nay là Ngày	Học Lớp Mấy ở Trường?

Người Điền Mẫu	☐ Phụ Huynh ☐ Họ Hàng ☐ Bạn Bè ☐ Người Giám Hộ ☐ Người Khác (Ghi Rõ)	Đi Học Có Thường Xuyên Không? ☐ Có ☐ Không

Vui lòng trả lời tất cả các câu hỏi trong mẫu này một cách tốt nhất có thể. Khoanh tròn "Bỏ Qua" nếu quý vị không biết câu trả lời hoặc không muốn trả lời. Hãy đảm bảo rằng quý vị sẽ hỏi bác sỹ nếu có thắc mắc liên quan đến bất kỳ điều gì trong mẫu này. Tất cả câu trả lời của quý vị sẽ được bảo vệ như một phần hồ sơ y tế của quý vị.

Cần Phiên Dịch? ☐ Có ☐ Không

Clinic Use Only:

					Nutrition
1	Con của quý vị có ăn hoặc uống 3 phần thực phẩm giàu canxi như sữa, pho mát, sữa chua, sữa đậu nành hoặc đậu phụ mỗi ngày không? *Child drinks/eats 3 servings of calcium-rich foods daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
2	Con quý vị có ăn trái cây và rau ít nhất hai lần mỗi ngày không? *Child eats fruits and vegetables at least two times per day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
3	Con của quý vị có ăn các thực phẩm nhiều chất béo như thực phẩm chiên rán, khoai tây chiên, kem, pizza nhiều hơn một lần mỗi tuần không? *Child eats high fat foods more than once per week?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
4	Con của quý vị mỗi ngày có uống nhiều hơn một cốc nhỏ (4 - 6 ao-xơ.) nước hoa quả không? *Child drinks more than one small cup of juice per day?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
5	Con của quý vị có uống nước xô-đa, nước hoa quả, đồ uống thể thao, nước tăng lực, hoặc đồ uống có đường khác nhiều hơn một lần mỗi tuần không? *Child drinks soda, juice/sports/energy drinks, or other sweetened drinks more than once per week?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
6	Con quý vị có tập thể dục, chơi thể thao hầu hết các ngày trong tuần không? *Child exercises or plays sports most days of the week?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Physical Activity
7	Quý vị có lo lắng về cân nặng của con không? *Concerned about child's weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	

8	Con quý vị có xem TV hoặc chơi trò chơi điện tử video dưới 2 tiếng mỗi ngày không? *Child watches TV or plays video games less than 2 hours per day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
9	Nhà quý vị có thiết bị báo khói đang hoạt động không? *Home has a working smoke detector?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Safety
10	Quý vị đã đặt nhiệt độ nước xuống mức ấm (dưới 120 độ) chưa? *Water temperature turned down to low-warm?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
11	Nhà quý vị có số điện thoại của Trung Tâm Kiểm Soát Chất Độc (800-222-1222) dán gần máy điện thoại không? *Home has phone # of the Poison Control Center posted by phone?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
12	Quý vị có luôn đặt con vào ghế nâng ở hàng ghế sau (hoặc thắt dây an toàn nếu con quý vị đã cao hơn 4'9") không? *Always places child in booster seat in back seat (or uses a seat belt) if child is over 4'9''?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
13	Con của quý vị có ở hay chơi gần bể bơi, sông hay hồ không? *Child spends time near a swimming pool, river, or lake?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
14	Con quý vị có ở hoặc chơi ở nhà có cất giữ súng không? *Child spends time in home where a gun is kept?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
15	Con quý vị có ở cùng hay chơi cùng bất kỳ ai có mang súng, dao hoặc vũ khí khác không? *Child spends time with anyone who carries a gun, knife, or other weapon?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
16	Con quý vị có luôn đội mũ bảo hiểm khi đi xe đạp, trượt ván hay đi xe trượt scooter không? *Child always wears a helmet when riding a bike, skateboard, or scooter?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
17	Con quý vị đã từng chứng kiến hoặc là nạn nhân của hành vi lạm dụng hay bạo lực chưa? *Child ever witnessed or been victim of abuse or violence?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
18	Con quý vị có bị đánh hoặc có đánh người khác trong năm vừa qua không? *Has child been hit or hit someone in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	

19	Con của quý vị có từng bị bắt nạt hoặc cảm thấy không an toàn ở trường hoặc ở khu lân cận của quý vị (hoặc bị bắt nạt trên internet) không? *Has child ever been bullied or felt unsafe at school/neighborhood (or been cyber-bullied)?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
20	Con quý vị có đánh răng và làm sạch kẽ răng mỗi ngày không? *Child brushes and flosses teeth daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Dental Health
21	Con của quý vị có thường có vẻ buồn hoặc chán nản không? *Child often seems sad or depressed?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Mental Health
22	Con quý vị có ở hay chơi cùng bất kỳ người hút thuốc nào không? *Child spends time with anyone who smokes?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Tobacco Exposure
23	Quý vị có bất kỳ thắc mắc hay lo lắng nào khác đến sức khỏe hoặc hành vi của con quý vị không? *Any other questions or concerns about child's health or behavior?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Other Questions

Nếu có, vui lòng mô tả:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **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:

Staying Healthy Assessment

9 – 11 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ 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:
					Nutrition
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one cup (8 oz.) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
					Physical Activity
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
					Safety
9	Does your home have a working smoke detector?	Yes	No	Skip	
10	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
11	Do your child always use a seat belt in the back seat (or use a booster seat if under 4'9")?	Yes	No	Skip	
12	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
13	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
14	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
15	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	

16	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
17	Has your child been hit or has your child hit someone in the past year?	No	Yes	Skip	
18	Has your child ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
19	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
20	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
21	Does your child spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Has your child ever smoked cigarettes or chewed tobacco?	No	Yes	Skip	
23	Are you concerned your child may be using drugs or sniffing substances, such as glue, to get high?	No	Yes	Skip	
24	Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?	No	Yes	Skip	
25	Does your child have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Has your child started dating or "going out" with boyfriends or girlfriends?	No	Yes	Skip	Sexual Issues
27	Do you think your child might be sexually active?	No	Yes	Skip	
28	Do you have any other questions or concerns about your child's health or behavior?	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:

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PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Evaluación de Salud

(Staying Healthy Assessment)

9 – 11 años *(9 – 11 Years)*

Nombre del niño (nombre y apellido)	Fecha de nacimiento	☐ mujer ☐ hombre	Fecha de hoy	¿Año escolar?
Persona que llena el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			Asistencia escolar ¿Regular? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no sabe una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre cualquier sección de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only:
					Nutrition
1	¿Su hijo bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *Child drinks/eats 3 servings of calcium-rich foods daily?*	Sí *Yes*	No	Omitir *Skip*	
2	¿Su hijo come frutas y verduras, al menos, 2 veces al día? *Child eats fruits and vegetables at least two times per day?*	Sí *Yes*	No	Omitir *Skip*	
3	¿Su hijo come alimentos con alto contenido de grasa, como alimentos fritos, papitas, helado o pizza más de una vez por semana? *Child eats high fat foods more than once per week?*	No	Sí *Yes*	Omitir *Skip*	
4	¿Su hijo bebe más de una taza (8 oz.) de jugo al día? *Child drinks more than one cup of juice per day?*	No	Sí *Yes*	Omitir *Skip*	
5	¿Su hijo toma refresco, jugos, bebidas deportivas, bebidas energizantes u otras bebidas endulzadas más de una vez por semana? *Child drinks soda, juice/sports/energy drinks or other sweetened drinks more than once per week?*	No	Sí *Yes*	Omitir *Skip*	
					Physical Activity
6	¿Su hijo hace ejercicio o juega deportes la mayoría de los días de la semana? *Child exercises or plays sports most days of the week?*	Sí *Yes*	No	Omitir *Skip*	
7	¿Le preocupa el peso de su hijo? *Concerned about child's weight?*	No	Sí *Yes*	Omitir *Skip*	
8	¿Su hijo ve televisión o juega juegos de video menos de 2 horas al día? *Child watches TV or plays video games less than 2 hours per day?*	Sí *Yes*	No	Omitir *Skip*	
					Safety
9	En su hogar, ¿hay un detector de humo que funcione? *Home has a working smoke detector?*	Sí *Yes*	No	Omitir *Skip*	
10	En su hogar, ¿está pegado cerca del teléfono el número del Centro de control de intoxicaciones (800-222-1222)? *Home has phone # of the Poison Control Center posted by phone?*	Sí *Yes*	No	Omitir *Skip*	

11	¿Su hijo siempre usa cinturón de seguridad en el asiento trasero (o usa un asiento para niños) si mide menos de 4'9"? *Child always uses a seat belt in the back seat (or booster seat) if under 4'9"?*	Sí *Yes*	No	Omitir *Skip*	
12	¿Su hijo pasa tiempo cerca de una piscina, río o lago? *Child spends time near a swimming pool, river, or lake?*	No	Sí *Yes*	Omitir *Skip*	
13	¿Su hijo pasa tiempo en un hogar donde hay un arma de fuego? *Child spends time in home where a gun is kept?*	No	Sí *Yes*	Omitir *Skip*	
14	¿Su hijo pasa tiempo con alguna persona que lleve un arma de fuego, un cuchillo u otra arma? *Child spends time with anyone who carries a gun, knife, or other weapon?*	No	Sí *Yes*	Omitir *Skip*	
15	¿Su hijo siempre usa casco cuando monta en bicicleta, patineta o *scooter*? *Child always wears a helmet when riding a bike, skateboard, or scooter?*	Sí *Yes*	No	Omitir *Skip*	
16	¿Su hijo ha presenciado o ha sido víctima de abuso o violencia? *Has child ever witnessed or been a victim of abuse or violence?*	No	Sí *Yes*	Omitir *Skip*	
17	¿Su hijo ha golpeado a alguien o alguien lo ha golpeado en el último año? *Has child been hit or has he/she hit someone in the past year?*	No	Sí *Yes*	Omitir *Skip*	
18	¿A su hijo alguna vez lo han acosado o se sintió inseguro en la escuela o su vecindario (o lo acosaron por Internet)? *Has child ever been bullied, felt unsafe at school/neighborhood (or been cyber-bullied)?*	No	Sí *Yes*	Omitir *Skip*	
19	¿Su hijo se cepilla los dientes y los limpia con hilo dental todos los días? *Child brushes and flosses teeth daily?*	Sí *Yes*	No	Omitir *Skip*	Dental Health
20	¿Su hijo con frecuencia parece triste o deprimido? *Child often seems sad or depressed?*	No	Sí *Yes*	Omitir *Skip*	Mental Health
21	¿Su hijo pasa tiempo con alguna persona que fuma? *Child spends time with anyone who smokes?*	No	Sí *Yes*	Omitir *Skip*	Alcohol, Tobacco, Drug Use
22	¿Su hijo ha fumado alguna vez cigarrillos o mascado tabaco? *Has child ever smoked cigarettes or chewed tobacco?*	No	Sí *Yes*	Omitir *Skip*	
23	¿Le preocupa a usted que su hijo pueda estar usando drogas, u oliendo sustancias tales como pegamento, para drogarse? *Concerned that child may be using drugs or sniffing substances to get high?*	No	Sí *Yes*	Omitir *Skip*	

24	¿Le preocupa que su hijo pueda estar tomando alcohol, tal como cerveza, vino, refrescos con contenido de alcohol o licor? *Concerned that child may be drinking alcohol?*	No	Sí *Yes*	Omitir *Skip*	
25	¿Su hijo tiene amigos o familiares que tienen problemas con las drogas o el alcohol? *Child has friends/family members who have problems with drugs or alcohol?*	No	Sí *Yes*	Omitir *Skip*	
26	¿Su hijo o hija ha empezado a salir con novios o novias? *Child started dating or "going out" with boyfriends or girlfriends?*	No	Sí *Yes*	Omitir *Skip*	
27	¿Cree que su hijo pueda estar sexualmente activo? *Thinks child might be sexually active?*	No	Sí *Yes*	Omitir *Skip*	
28	¿Tiene alguna otra pregunta o inquietud sobre la salud o conducta de su hijo? *Questions or concerns about child's health or behavior?*	No	Sí *Yes*	Omitir *Skip*	Other Questions

Si la respuesta es afirmativa, describa, por favor:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **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:

保持健康評估

(Staying Healthy Assessment)

9-11歲 *(9-11 years)*

孩童姓名（名和姓）	出生日期	☐女 ☐男	當日日期	學校年級
填表人	☐父母 ☐親屬 ☐朋友 ☐監護人 ☐其他（請註明）			學校出席 正常？☐是 ☐否

請儘量回答本表格所有的問題。如果您不知道答案或不想回答，請圈選「跳過」。如果對本表格有任何問題，請一定要問醫生。您的回答將與您的醫療記錄一同受到保護。

需要翻譯員嗎？ ☐是 ☐否

					Clinic Use Only:
					Nutrition
1	您小孩有沒有每天喝或吃3份高鈣食品，例如牛奶、乳酪、優格乳、豆漿或豆腐？ *Child drinks/eats 3 servings of calcium-rich foods daily?*	是 *Yes*	否 *No*	跳過 *Skip*	
2	您小孩是否每天至少吃兩次蔬菜水果？ *Child eats fruits and vegetables at least two times per day?*	是 *Yes*	否 *No*	跳過 *Skip*	
3	您小孩是否一星期超過一次吃高脂食品，如油炸食物、洋芋片、冰淇淋或披薩？ *Child eats high fat foods more than once per week?*	否 *No*	是 *Yes*	跳過 *Skip*	
4	您小孩是否每天喝超過一杯的（8盎斯）果汁？ *Child drinks more than one cup of juice per day?*	否 *No*	是 *Yes*	跳過 *Skip*	
5	您小孩是否一週喝超過一次蘇打飲料、果汁飲料、運動飲料、能量飲料或其他添加糖份飲料？ *Child drinks soda, juice/sports/energy drinks or other sweetened drinks more than once per week?*	否 *No*	是 *Yes*	跳過 *Skip*	
					Physical Activity
6	您小孩有沒有每週多日做運動或參加運動項目？ *Child exercises or plays sports most days of the week?*	是 *Yes*	否 *No*	跳過 *Skip*	
7	您擔心您小孩的體重嗎？ *Concerned about child's weight?*	否 *No*	是 *Yes*	跳過 *Skip*	
8	您小孩是否每天看少於2小時的電視或玩電動遊戲？ *Child watches TV or plays video games less than 2 hours per day?*	是 *Yes*	否 *No*	跳過 *Skip*	
					Safety
9	您家裡有功能正常的煙霧偵測器嗎？ *Home has a working smoke detector?*	是 *Yes*	否 *No*	跳過 *Skip*	
10	您家裡電話旁邊貼著毒物控制中心（800-222-1222）的電話號碼嗎？ *Home has phone # of the Poison Control Center posted by phone?*	是 *Yes*	否 *No*	跳過 *Skip*	

11	您小孩是否總是繫安全帶坐在車後座（或如身高低於 4’ 9” ，使用加高座椅）？ *Child always uses a seat belt in the back seat (or booster seat) if under 4’9”?*	是 *Yes*	否 *No*	跳過 *Skip*	
12	您小孩是否會在游泳池附近、河邊或湖邊待一段時間？ *Child spends time near a swimming pool, river, or lake?*	否 *No*	是 *Yes*	跳過 *Skip*	
13	您小孩會待在有槍枝的家中嗎？ *Child spends time in home where a gun is kept?*	否 *No*	是 *Yes*	跳過 *Skip*	
14	您小孩是否有時與任何攜帶槍、刀或其他武器的人在一起？ *Child spends time with anyone who carries a gun, knife, or other weapon?*	否 *No*	是 *Yes*	跳過 *Skip*	
15	您小孩騎自行車、*玩滑板或滑板車時是否總是戴安全帽？* *Child always wears helmet when riding a bike, skateboard, or scooter?*	是 *Yes*	否 *No*	跳過 *Skip*	
16	您小孩是否曾目睹虐待或暴力，或者本身是虐待或暴力受害者？ *Has child ever witnessed or been a victim of abuse or violence?*	否 *No*	是 *Yes*	跳過 *Skip*	
17	您小孩在過去的一年是否被打或打人？ *Has child been hit or has he/she hit someone in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
18	您小孩是否曾在學校或您居家附近被人欺負，或感到不安全（或在網絡被欺負）？ *Has child ever been bullied, felt unsafe at school/neighborhood (or been cyber-bullied)?*	否 *No*	是 *Yes*	跳過 *Skip*	
19	您小孩每天都有刷牙和使用牙線嗎？ *Child brushes and flosses teeth daily?*	是 *Yes*	否 *No*	跳過 *Skip*	Dental Health
20	您的小孩是否經常顯得悲傷或沮喪？ *Child often seems sad or depressed?)*	否 *No*	是 *Yes*	跳過 *Skip*	Mental Health
21	您小孩是否有時與抽煙的人在一起？ *Child spends time with anyone who smokes?*	否 *No*	是 *Yes*	跳過 *Skip*	Alcohol, Tobacco, Drug Use
22	您小孩是否曾經吸煙或嚼煙？ *Has child ever smoked cigarettes or chewed tobacco?*	否 *No*	是 *Yes*	跳過 *Skip*	

23	您是否擔心您小孩可能用藥或吸食物質，如膠水，以追求快感？ *Concerned that child may be using drugs or sniffing substances to get high?*	否 *No*	是 *Yes*	跳過 *Skip*	
24	您是否擔心您小孩可能飲酒，如啤酒，葡萄酒，水果葡萄酒或烈酒？ *Concerned that child may be drinking alcohol?*	否 *No*	是 *Yes*	跳過 *Skip*	
25	您小孩是否有吸毒或酗酒問題的朋友或家庭成員？ *Child has friends/family members who have problems with drugs or alcohol?*	否 *No*	是 *Yes*	跳過 *Skip*	
26	您小孩是否開始約會或與女朋友或男朋友「外出」？ *Child started dating or "going out" with boyfriends or girlfriends?*	否 *No*	是 *Yes*	跳過 *Skip*	Sexual Issues
27	您覺得您小孩可能已有性行為？ *Thinks child might be sexually active?*	否 *No*	是 *Yes*	跳過 *Skip*	
28	您是否有任何其他關於您小孩健康或行為上的問題或疑慮？ *Questions or concerns about child's health or behavior?*	否 *No*	是 *Yes*	跳過 *Skip*	Other Questions

若回答是，請描述：

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:

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PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Đánh Giá về Giữ Gìn Sức Khỏe

(Staying Healthy Assessment)

9 – 11 Tuổi *(9 – 11 Years)*

Tên của Trẻ (tên & họ)	Ngày Sinh	☐ Nữ ☐ Nam	Hôm Nay là Ngày	Lớp Mấy ở Trường:
Người Điền Mẫu	☐ Phụ Huynh ☐ Họ Hàng ☐ Bạn Bè ☐ Người Giám Hộ ☐ Người Khác (Ghi Rõ)			Đi Học Có Thường Xuyên Không? ☐ Có ☐ Không

Vui lòng trả lời tất cả các câu hỏi trong mẫu này một cách tốt nhất có thể. Khoanh tròn "Bỏ Qua" nếu quý vị không biết câu trả lời hoặc không muốn trả lời. Hãy đảm bảo rằng quý vị sẽ hỏi bác sỹ nếu có thắc mắc liên quan đến bất kỳ điều gì trong mẫu này. Tất cả câu trả lời của quý vị sẽ được bảo vệ như một phần hồ sơ y tế của quý vị.

Cần Phiên Dịch?
☐ Có ☐ Không

Clinic Use Only:

					Nutrition
1	Con của quý vị có ăn hoặc uống 3 phần thực phẩm giàu canxi như sữa, pho mát, sữa chua, sữa đậu nành hoặc đậu phụ mỗi ngày không? *Child drinks/eats 3 servings of calcium-rich foods daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
2	Con quý vị có ăn trái cây và rau ít nhất hai lần mỗi ngày không? *Child eats fruits and vegetables at least two times per day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
3	Con của quý vị có ăn các thực phẩm nhiều chất béo như thực phẩm chiên rán, khoai tây chiên, kem, pizza nhiều hơn một lần mỗi tuần không? *Child eats high fat foods more than once per week?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
4	Con quý vị mỗi ngày có uống nhiều hơn một cốc (8 ao-xơ.) nước hoa quả? *Child drinks more than one cup of juice per day?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
5	Con quý vị có uống nước xô-đa, nước hoa quả, đồ uống thể thao/nước tăng lực, hoặc nước uống có đường khác nhiều hơn một lần mỗi tuần không? *Child drinks soda, juice/sports/energy drinks or other sweetened drinks more than once per week?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
					Physical Activity
6	Con quý vị có tập thể dục, chơi thể thao hầu hết các ngày trong tuần không? *Child exercises or plays sports most days of the week?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
7	Quý vị có lo lắng về cân nặng của con không? *Concerned about child's weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
8	Con quý vị có xem TV hoặc chơi trò chơi điện tử video dưới 2 tiếng mỗi ngày không? *Child watches TV or plays video games less than 2 hours per day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	

9	Nhà quý vị có thiết bị báo khói đang hoạt động không? *Home has a working smoke detector?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Safety
10	Nhà quý vị có số điện thoại của Trung Tâm Kiểm Soát Chất Độc (800-222-1222) được dán gần máy điện thoại không? *Home has phone # of the Poison Control Center posted by phone?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
11	Con của quý vị có luôn dùng dây an toàn ở ghế sau (hoặc sử dụng ghế nâng nếu cao dưới 4'9") không? *Child always uses a seat belt in the back seat (or booster seat) if under 4'9"?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
12	Con của quý vị có ở hay chơi gần bể bơi, sông hay hồ không? *Child spends time near a swimming pool, river, or lake?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
13	Con quý vị có ở hoặc chơi ở nhà có cất giữ súng không? *Child spends time in home where a gun is kept?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
14	Con quý vị có ở cùng hay chơi cùng bất kỳ ai có mang súng, dao hoặc vũ khí khác không? *Child spends time with anyone who carries a gun, knife, or other weapon?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
15	Con quý vị có luôn đội mũ bảo hiểm khi đi xe đạp, trượt ván hay đi xe scooter không? *Child always wears a helmet when riding a bike, skateboard, or scooter?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
16	Con quý vị đã bao giờ chứng kiến hoặc là nạn nhân của hành vi lạm dụng hay bạo lực chưa? *Has child ever witnessed or been a victim of abuse or violence?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
17	Con quý vị có bị đánh hoặc có đánh người khác trong năm vừa qua không? *Has child been hit or has he/she hit someone in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
18	Con quý vị đã bao giờ bị bắt nạt, cảm thấy không an toàn ở trường hoặc ở khu lân cận của quý vị (hoặc bị bắt nạt trên internet) hay chưa? *Has child ever been bullied, felt unsafe at school/neighborhood (or been cyber-bullied)?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
19	Con quý vị có đánh răng và làm sạch kẽ răng mỗi ngày không? *Child brushes and flosses teeth daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Dental Health
20	Con của quý vị có thường có vẻ buồn hoặc chán nản không? *Child often seems sad or depressed?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Mental Health
21	Con quý vị có ở hay chơi cùng bất kỳ người hút thuốc nào không? *Child spends time with anyone who smokes?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Alcohol, Tobacco, Drug Use

22	Con quý vị đã bao giờ hút thuốc hoặc nhai thuốc lá hay chưa? *Has child ever smoked cigarettes or chewed tobacco?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
23	Quý vị có lo lắng về việc liệu con mình có thể đang sử dụng ma túy hoặc hít các dược chất như keo dán để có cảm giác hưng phấn hay không? *Concerned that child may be using drugs or sniffing substances to get high?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
24	Quý vị có lo lắng về việc liệu con mình có thể đang dùng đồ uống chứa cồn chẳng hạn như bia, rượu vang, rượu pha nước trái cây hay rượu nặng hay không? *Concerned that child may be drinking alcohol?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
25	Con quý vị có bạn bè hay thành viên trong gia đình có vấn đề về ma túy hoặc rượu hay không? *Child has friends/family members who have problems with drugs or alcohol?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
26	Con quý vị đã bắt đầu hẹn hò hay "đi chơi" với bạn trai hay bạn gái hay chưa? *Child started dating or "going out" with boyfriends or girlfriends?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Sexual Issues
27	Quý vị có nghĩ rằng con mình có thể đã sinh hoạt tình dục hay không? *Thinks child might be sexually active?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
28	Quý vị có bất kỳ thắc mắc hay lo lắng nào khác đến sức khỏe hoặc hành vi của con quý vị không? *Questions or concerns about child's health or behavior?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Other Questions

Nếu có, vui lòng mô tả:

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:

Staying Healthy Assessment

12 – 17 Years

Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School:
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ 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 at least 2 times per day?	Yes	No	Skip	
3	Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Yes	Skip	
5	Do you exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
6	Are you concerned about your weight?	No	Yes	Skip	
7	Do you watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
8	Does your home have a working smoke detector?	Yes	No	Skip	Safety
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
10	Do you always wear a seatbelt when riding in a car?	Yes	No	Skip	
11	Do you spend time in a home where a gun is kept?	No	Yes	Skip	
12	Do you spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
13	Do you always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
14	Have you ever witnessed abuse or violence?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?	No	Yes	Skip	
16	Have you ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, down, or hopeless?	No	Yes	Skip	Mental Health
19	Do you spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
20	Do you smoke cigarettes or chew tobacco?	No	Yes	Skip	
21	Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?	No	Yes	Skip	

22	Do you use medicines not prescribed for you?	No	Yes	Skip	
23	Do you drink alcohol once a week or more?	No	Yes	Skip	
24	If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes	Skip	
25	Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes	Skip	
	Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.				
27	Have you ever been forced or pressured to have sex?	No	Yes	Skip	Sexual Issues
28	Have you ever had sex (oral, vaginal, or anal)? *If no, skip to question 35.*	No	Yes	Skip	
29	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
30	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
31	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
32	The last time you had sex, did you use birth control?	Yes	No	Skip	
33	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
34	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip	
35	Do you have any questions about your sexual orientation (who you are attracted to) or gender identity (how you feel as a boy, girl, or other gender)?	No	Yes	Skip	
36	Do you have any 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	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **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:

Evaluación de Salud

(Staying Healthy Assessment)

12 – 17 años *(12 – 17 Years)*

Nombre (primer nombre y apellido)	Fecha de nacimiento	☐ mujer ☐ hombre	Fecha de hoy	Año escolar
Persona que completa el formulario	☐ Padre/madre ☐ Familiar ☐ Amigo ☐ Tutor ☐ Otro (especifique)			Asistencia escolar ¿Regular? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no conoce una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre algún punto de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only:
1	¿Bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *Drinks/eats 3 servings of calcium-rich foods daily?*	Sí *Yes*	No	Omitir *Skip*	Nutrition
2	¿Come frutas y verduras, al menos, 2 veces al día? *Eats fruits and vegetables at least 2 times per day?*	Sí *Yes*	No	Omitir *Skip*	
3	¿Come comidas con alto contenido de grasa, como comidas fritas, papitas, helado o pizza más de una vez por semana? *Eats high fat foods more than once per week?*	No	Sí *Yes*	Omitir *Skip*	
4	¿Bebe más de 12 oz (1 lata de refresco) por día de jugo, bebida deportiva, bebida energizante o bebida de café endulzada? *Drinks more than 12 oz. per day of juice/sports/energy drink, or sweetened coffee drink?*	No	Sí *Yes*	Omitir *Skip*	
5	¿Hace ejercicio o deporte la mayoría de los días? *Exercises or plays sports most days of the week?*	Sí *Yes*	No	Omitir *Skip*	Physical Activity
6	¿Le preocupa su peso? *Concerned about weight?*	No	Sí *Yes*	Omitir *Skip*	
7	¿Mira televisión o juega juegos de video menos de 2 horas al día? *Watches TV or plays video games less than 2 hours per day?*	Sí *Yes*	No	Omitir *Skip*	
8	En su hogar, ¿hay un detector de humo que funcione? *Home has working smoke detector?*	Sí *Yes*	No	Omitir *Skip*	Safety
9	En su hogar, ¿está pegado cerca del teléfono el número del Centro de intoxicaciones (800-222-1222)? *Home has phone # of the Poison Control Center posted by phone?*	Sí *Yes*	No	Omitir *Skip*	
10	¿Siempre usa cinturón de seguridad cuando viaja en automóvil? *Always wears a seatbelt when riding in a car?*	Sí *Yes*	No	Omitir *Skip*	
11	¿Pasa tiempo en un hogar donde hay un revólver? *Spends time in a home where a gun is kept?*	No	Sí *Yes*	Omitir *Skip*	
12	¿Pasa tiempo con alguna persona que lleve un revólver, un cuchillo u otra arma? *Spends time with anyone who carries a gun, knife, or other weapon?*	No	Sí *Yes*	Omitir *Skip*	

13	¿Siempre usa casco cuando va en bicicleta, patineta o *scooter*? *Always wears a helmet when riding a bike, skateboard, or scooter?*	Sí *Yes*	No	Omitir *Skip*	
14	¿Alguna vez ha presenciado un acto de abuso o violencia? *Ever witnessed abuse or violence?*	No	Sí *Yes*	Omitir *Skip*	
15	Durante el último año, ¿alguien lo ha golpeado, abofeteado o lastimado físicamente (o ha lastimado usted a alguien)? *Been hit, slapped, kicked, or physically hurt by someone (or has he/she hurt someone) in the past year?*	No	Sí *Yes*	Omitir *Skip*	
16	¿Alguna vez lo han intimidado o se sintió inseguro en su escuela o barrio (o lo intimidaron por Internet)? *Ever been bullied or felt unsafe at school/neighborhood (or been cyber-bullied)?*	No	Sí *Yes*	Omitir *Skip*	
17	¿Se cepilla los dientes y los limpia con hilo dental todos los días? *Brushes and flosses teeth daily?*	Sí *Yes*	No	Omitir *Skip*	Dental Health
18	¿Con frecuencia se siente triste, deprimido o desesperanzado? *Often feels sad, down, or hopeless?*	No	Sí *Yes*	Omitir *Skip*	Mental Health
19	¿Pasa tiempo con alguna persona que fuma? *Spends time with anyone who smokes?*	No	Sí *Yes*	Omitir *Skip*	Alcohol, Tobacco, Drug Use
20	¿Fuma cigarrillos o mastica tabaco? *Smokes cigarettes or chews tobacco?*	No	Sí *Yes*	Omitir *Skip*	
21	¿Consume o aspira alguna sustancia para drogarse, como marihuana, cocaína, *crack*, metanfetamina ("*meth*"), éxtasis, etc.? *Uses or sniffs any substance to get high?*	No	Sí *Yes*	Omitir *Skip*	
22	¿Utiliza medicamentos que no fueron recetados para usted? *Uses medicines not prescribed for her/him?*	No	Sí *Yes*	Omitir *Skip*	
23	¿Bebe alcohol una vez a la semana o más? *Drinks alcohol once a week or more?*	No	Sí *Yes*	Omitir *Skip*	
24	Si bebe alcohol, ¿bebe hasta emborracharse o desmayarse? *If she/he drinks alcohol, drinks enough to get drunk or pass out?*	No	Sí *Yes*	Omitir *Skip*	
25	¿Tiene amigos o familiares que tienen problemas con las drogas o el alcohol? *Has friends/family members who have problems with drugs or alcohol?*	No	Sí *Yes*	Omitir *Skip*	
26	¿Conduce un automóvil después de beber, o viaja en un automóvil conducido por una persona que ha bebido o consumido drogas? *Drives a car after drinking, or rides in a car driven by someone who has been drinking or using drugs?*	No	Sí *Yes*	Omitir *Skip*	
Sus respuestas sobre relaciones sexuales o planificación familiar no serán divulgadas a nadie, ni siquiera a sus padres, sin su permiso.					
27	¿Alguna vez lo forzaron o presionaron para tener relaciones sexuales? *Ever been forced or pressured to have sex?*	No	Sí *Yes*	Omitir *Skip*	Sexual Issues
28	¿Alguna vez ha tenido relaciones sexuales (orales, vaginales o anales)? *Si la respuesta es "no", pase a la pregunta 35.* *Ever had sex (oral, vaginal, or anal)?*	No	Sí *Yes*	Omitir *Skip*	
29	¿Cree que usted o su pareja pueden tener una infección de transmisión sexual (sexually transmitted infection, STI), como clamidia, gonorrea, verrugas genitales, etc.? *Thinks she/he or partner could have a STI?*	No	Sí *Yes*	Omitir *Skip*	

30	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales con otras personas en el último año? *She/he or partner(s) had sex with other people in the past year?*	No	Sí *Yes*	Omitir *Skip*	
31	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin utilizar un método anticonceptivo en el último año? *She/he or partner(s) had sex without using birth control in the past year?*	No	Sí *Yes*	Omitir *Skip*	
32	La última vez que tuvo relaciones sexuales, ¿utilizó un método anticonceptivo? *Used birth control the last time she/he had sex?*	Sí *Yes*	No	Omitir *Skip*	
33	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin condón en el último año? *She/he or partner(s) had sex without a condom in the past year?*	No	Sí *Yes*	Omitir *Skip*	
34	¿Usted o su pareja usaron un condón la última vez que tuvieron relaciones sexuales? *She/he or partner used a condom the last time they had sex?*	Sí *Yes*	No	Omitir *Skip*	
35	¿Tiene alguna pregunta sobre su orientación sexual (que estás atraído a) o la identidad de género (cómo se siente como un niño, niña, o de otro género)? *Any questions about sexual orientation or gender identity?*	No	Sí *Yes*	Omitir *Skip*	
36	¿Tiene alguna otra pregunta o inquietud sobre su salud? *Any other questions or concerns about health?*	No	Sí *Yes*	Omitir *Skip*	Other Questions

Si la respuesta es afirmativa, describa, por favor:

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:

保持健康評估

(Staying Healthy Assessment)

12-17歲 *(12 – 17 Years)*

姓名（名和姓）	出生日期	☐女 ☐男	當日日期	學校年級
填表人	☐父母 ☐親屬 ☐朋友 ☐監護人 ☐其他（請註明）			學校出席 正常？☐是 ☐否

請儘量回答本表格所有的問題。如果您不知道答案或不想回答，請圈選「跳過」。如果對本表格有任何問題，請一定要問醫生。您的回答將與您的醫療記錄一同受到保護。

需要翻譯員嗎？ ☐是 ☐否

					Clinic Use Only:
					Nutrition
1	您有沒有每天喝或吃3份高鈣食品，例如牛奶、乳酪、優格乳、豆漿或豆腐？ *Drinks/eats 3 servings of calcium-rich foods daily?*	是 *Yes*	否 *No*	跳過 *Skip*	
2	您是否每天至少吃兩次蔬菜水果？ *Eats fruits and vegetables at least 2 times per day?*	是 *Yes*	否 *No*	跳過 *Skip*	
3	您是否一星期超過一次吃高脂食品，如油炸食物、洋芋片、冰淇淋或披薩？ *Eats high fat foods more than once per week?*	否 *No*	是 *Yes*	跳過 *Skip*	
4	您是否每天喝超過12盎斯（1蘇打飲料罐）的果汁飲料、運動飲料、能量飲料或加糖咖啡飲料？ *Drinks more than 12 oz. per day of juice/sports/energy drink, or sweetened coffee drink?*	否 *No*	是 *Yes*	跳過 *Skip*	
					Physical Activity
5	您有沒有每週多日做運動或參加運動項目？ *Exercises or plays sports most days of the week?*	是 *Yes*	否 *No*	跳過 *Skip*	
6	您擔心您的體重嗎？ *Concerned about weight?*	否 *No*	是 *Yes*	跳過 *Skip*	
7	您是否每天看少於2小時的電視或玩電動遊戲？ *Watches TV or plays video games less than 2 hours per day?*	是 *Yes*	否 *No*	跳過 *Skip*	
					Safety
8	您家裡有功能正常的煙霧偵測器嗎？ *Home has working smoke detector?*	是 *Yes*	否 *No*	跳過 *Skip*	
9	您家裡電話旁邊貼著毒物控制中心（800-222-1222）的電話號碼嗎？ *Home has phone # of the Poison Control Center posted by phone?*	是 *Yes*	否 *No*	跳過 *Skip*	
10	您是否乘車時總是繫安全帶？ *Always wears a seat belt when riding in a car?*	是 *Yes*	否 *No*	跳過 *Skip*	
11	您會待在有槍枝的家中嗎？ *Spends time in a home where a gun is kept?*	否 *No*	是 *Yes*	跳過 *Skip*	
12	您是否有時與任何攜帶槍、刀或其他武器的人在一起？ *Spends time with anyone who carries a gun, knife, or other weapon?*	否 *No*	是 *Yes*	跳過 *Skip*	

13	您騎自行車、玩滑板或滑板車時是否總是戴安全帽？ *Always wears a helmet when riding a bike, skateboard, or scooter?*	是 *Yes*	否 *No*	跳過 *Skip*	
14	你有沒有親眼目睹過虐待或暴力？ *Ever witnessed abuse or violence?*	否 *No*	是 *Yes*	跳過 *Skip*	
15	在過去一年中您有沒有被打、打耳光、被踢，或被傷害身體（或您傷害別人）？ *Been hit, slapped, kicked, or physically hurt by someone (or has he/she hurt someone) in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
16	您是否曾在學校或您居家附近被人欺負，或感到不安全（或在網絡被欺負）？ *Ever been bullied or felt unsafe at school/neighborhood (or been cyber-bullied)?*	否 *No*	是 *Yes*	跳過 *Skip*	
17	您每天都有刷牙和使用牙線嗎？ *Brushes and flosses teeth daily?*	是 *Yes*	否 *No*	跳過 *Skip*	Dental Health
18	你是否經常感到傷心，沮喪，或絕望？ *Often feels sad, down, or hopeless?*	否 *No*	是 *Yes*	跳過 *Skip*	Mental Health
19	您是否有時與抽煙的人在一起？ *Spends time with anyone who smokes?*	否 *No*	是 *Yes*	跳過 *Skip*	Alcohol, Tobacco, Drug Use
20	你是否抽煙或嚼煙？ *Smokes cigarettes or chews tobacco?*	否 *No*	是 *Yes*	跳過 *Skip*	
21	您是否用藥或吸食物質以追求快感，例如大麻、古柯鹼、快克、安非他命、迷幻藥等？ *Uses or sniffs any substance to get high?*	否 *No*	是 *Yes*	跳過 *Skip*	
22	您是否服用不是開給您的處方藥？ *Uses medicines not prescribed for her/him?*	否 *No*	是 *Yes*	跳過 *Skip*	
23	您是否每週喝一次或更多次酒？ *Drinks alcohol once a week or more?*	否 *No*	是 *Yes*	跳過 *Skip*	
24	如果您喝酒，您是否會喝到醉或失去知覺？ *If she/he drinks alcohol, drinks enough to get drunk or pass out?*	否 *No*	是 *Yes*	跳過 *Skip*	
25	您是否有吸毒或酗酒問題的朋友或家庭成員？ *Has friends/family members who have problems with drugs or alcohol?*	否 *No*	是 *Yes*	跳過 *Skip*	
26	您是否酒後駕車，或乘坐由酒醉或用藥的人開的車？ *Drives a car after drinking, or rides in a car driven by someone who has been drinking or using drugs?*	否 *No*	是 *Yes*	跳過 *Skip*	
	關於您對性與計劃生育的回答，如無您的許可不會提供給任何人，包括您父母。				
27	你有沒有曾被強迫或被施加壓力而發生性關係？ *Ever been forced or pressured to have sex?*	否 *No*	是 *Yes*	跳過 *Skip*	Sexual Issues
28	您曾有過性交（口交、陰道或肛門）？ *Ever had sex (oral, vaginal, or anal)?*	否 *No*	是 *Yes*	跳過 *Skip*	
29	你是否覺得您或您的伴侶可能得了性傳播感染（STI），如衣原體，淋病，生殖器疣等？ *Thinks she/he or partner could have a STI?*	否 *No*	是 *Yes*	跳過 *Skip*	

30	您或您的伴侶在過去一年中曾和其他人發生性關係嗎？ *She/he or partner(s) had sex with other people in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
31	您或您的伴侶在過去一年中性交時沒有使用避孕方法嗎? *She/he or partner(s) had sex without using birth control in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
32	您最後一次性交時，有沒有使用避孕方法？ *Used birth control the last time she/he had sex?*	是 *Yes*	否 *No*	跳過 *Skip*	
33	您或您的伴侶在過去一年中性交時沒有使用保險套嗎？ *She/he or partner(s) had sex without a condom in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
34	您或您的伴侶最後一次性交時，有沒有使用保險套？ *She/he or partner used a condom the last time they had sex?*	是 *Yes*	否 *No*	跳過 *Skip*	
35	您是否對您的性傾向（您對誰有興趣）或性別認同（對於做為男生、女生或別的性別的感覺）有任何疑問？ *Any questions about sexual orientation or gender identity?*	否 *No*	是 *Yes*	跳過 *Skip*	
36	您是否有任何其他關於您健康上的問題或疑慮？ *Any other questions or concerns about health?*	否 *No*	是 *Yes*	跳過 *Skip*	Other Questions

若回答是，請描述：

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:

Đánh Giá về Giữ Gìn Sức Khỏe

(Staying Healthy Assessment)

12 – 17 Tuổi *(12 – 17 Years)*

Tên (tên & họ)	Ngày Sinh	☐ Nữ ☐ Nam	Hôm Nay là Ngày	Lớp Mấy ở Trường:
Người Điền Mẫu	☐ Phụ Huynh ☐ Họ Hàng ☐ Bạn Bè ☐ Người Giám Hộ ☐ Người khác (Ghi rõ)			Đi Học Có Thường Xuyên Không? ☐ Có ☐ Không

Vui lòng trả lời tất cả các câu hỏi trong mẫu này một cách tốt nhất có thể. Khoanh tròn "Bỏ Qua" nếu quý vị không biết câu trả lời hoặc không muốn trả lời. Hãy đảm bảo rằng quý vị sẽ hỏi bác sỹ nếu có thắc mắc liên quan đến bất kỳ điều gì trong mẫu này. Tất cả câu trả lời của quý vị sẽ được bảo vệ như một phần hồ sơ y tế của quý vị.

Cần Phiên Dịch? ☐ Có ☐ Không

Clinic Use Only:

1	Quý vị có uống hoặc ăn 3 phần thực phẩm giàu canxi chẳng hạn như sữa, pho mát, sữa chua, sữa đậu nành hoặc đậu phụ hàng ngày hay không? *Drinks/eats 3 servings of calcium-rich foods daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Nutrition
2	Quý vị có ăn trái cây và rau ít nhất 2 lần mỗi ngày hay không? *Eats fruits and vegetables at least 2 times per day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
3	Quý vị có ăn thực phẩm có hàm lượng chất béo cao chẳng hạn như thức ăn chiên rán, khoai tây chiên, kem hay bánh pizza nhiều hơn một lần mỗi tuần hay không? *Eats high fat foods more than once per week?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
4	Mỗi ngày quý vị có uống nhiều hơn 12 ao xơ (1 lon xô-đa) nước ép trái cây, đồ uống thể thao, nước tăng lực hoặc cà phê có đường hay không? *Drinks more than 12 oz. per day of juice/sports/energy drink, or sweetened coffee drink?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
5	Quý vị có tập thể dục hay chơi thể thao hầu hết các ngày trong tuần không? *Exercises or plays sports most days of the week?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Physical Activity
6	Quý vị có lo lắng về cân nặng của mình hay không? *Concerned about weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
7	Quý vị có xem ti vi hay chơi trò chơi điện tử video ít hơn 2 tiếng mỗi ngày hay không? *Watches TV or plays video games less than 2 hours per day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
8	Nhà quý vị có thiết bị báo khói đang hoạt động không? *Home has working smoke detector?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Safety
9	Nhà quý vị có số điện thoại của Trung Tâm Kiểm Soát Chất Độc (800-222-1222) được dán gần máy điện thoại không? *Home has phone # of the Poison Control Center posted by phone?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
10	Quý vị có luôn thắt dây an toàn khi đi trên xe ôtô không? *Always wears a seatbelt when riding in a car?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
11	Quý vị có ở hay chơi ở nhà có cất súng không? *Spends time in a home where a gun is kept?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	

12	Quý vị có chơi với ai có mang súng, dao hoặc vũ khí khác không? *Spends time with anyone who carries a gun, knife, or other weapon?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
13	Quý vị có luôn đội mũ bảo hiểm khi đi xe đạp, trượt ván hoặc đi xe trượt scooter không? *Always wears a helmet when riding a bike, skateboard, or scooter?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
14	Quý vị đã bao giờ chứng kiến hành vi lạm dụng hay bạo lực hay chưa? *Ever witnessed abuse or violence?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
15	Quý vị có bị người nào đánh, bạt tai, đá hoặc làm bị thương thân thể (hay quý vị có làm người khác bị thương) trong năm vừa qua không? *Been hit, slapped, kicked, or physically hurt by someone (or has he/she hurt someone) in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
16	Quý vị đã bao giờ bị bắt nạt hoặc cảm thấy không an toàn khi ở trường hoặc khu lân cận (hoặc bị bắt nạt trên internet) hay chưa? *Ever been bullied or felt unsafe at school/neighborhood (or been cyber-bullied)?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
17	Quý vị có đánh răng hay làm sạch kẽ răng của mình hàng ngày hay không? *Brushes and flosses teeth daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Dental Health
18	Quý vị có thường cảm thấy buồn, chán nản hay tuyệt vọng hay không? *Often feels sad, down, or hopeless?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Mental Health
19	Quý vị có ở hay chơi cùng ai có hút thuốc hay không? *Spends time with anyone who smokes?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Alcohol, Tobacco, Drug Use
20	Quý vị có hút thuốc hoặc nhai thuốc lá hay không? *Smokes cigarettes or chews tobacco?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
21	Quý vị có sử dụng hay hít bất kỳ dược chất nào để có cảm giác hưng phấn chẳng hạn như cần sa, côcain, côcain nguyên chất, Methamphetamine (meth), thuốc kích thích, v.v… hay không? *Uses or sniffs any substance to get high?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
22	Quý vị có sử dụng dược phẩm không kê theo toa cho mình hay không? *Uses medicines not prescribed for her/him?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
23	Quý vị có uống rượu một lần một tuần trở lên hay không? *Drinks alcohol once a week or more?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
24	Nếu quý vị uống rượu, quý vị có uống đến mức say hoặc không tỉnh táo hay không? *If she/he drinks alcohol, drinks enough to get drunk or pass out?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
25	Quý vị có bạn bè hoặc thành viên trong gia đình gặp vấn đề về ma túy hay rượu không? *Has friends/family members who have problems with drugs or alcohol?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
26	Quý vị có lái xe sau khi uống rượu hoặc đi trên xe được lái bởi người đã uống rượu hoặc sử dụng ma túy không? *Drives a car after drinking, or rides in a car driven by someone who has been drinking or using drugs?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	

Chúng tôi không thể chia sẻ câu trả lời của quý vị về giới tính và kế hoạch hóa gia đình với bất kỳ ai, kể cả phụ huynh của quý vị mà không có sự cho phép của quý vị.

27	Quý vị đã bao giờ bị cưỡng ép hoặc bị áp lực phải quan hệ tình dục hay chưa? *Ever been forced or pressured to have sex?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Sexual Issues
28	Quý vị đã bao giờ quan hệ tình dục (bằng đường miệng, âm đạo hoặc hậu môn) hay chưa? *Nếu không, hãy bỏ qua đến câu hỏi 35.* *Ever had sex (oral, vaginal, or anal)?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
29	Quý vị có nghĩ mình hoặc bạn tình của mình có thể mắc bệnh lây nhiễm qua đường tình dục (STI) chẳng hạn như, Chlamydia, Bệnh Lậu, sùi mào gà, v.v… không? *Thinks she/he or partner could have a STI?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
30	Quý vị hay (những) bạn tình của mình có quan hệ tình dục với những người khác trong năm vừa qua không? *She/he or partner(s) had sex with other people in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
31	Quý vị hoặc (những) bạn tình của mình có quan hệ tình dục mà không sử dụng biện pháp ngừa thai trong năm vừa qua không? *She/he or partner(s) had sex without using birth control in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
32	Quý vị có sử dụng biện pháp ngừa thai trong lần quan hệ tình dục gần đây nhất không? *Used birth control the last time she/he had sex?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
33	Quý vị hoặc (những) bạn tình của mình có quan hệ tình dục mà không sử dụng bao cao su trong năm vừa qua không? *She/he or partner(s) had sex without a condom in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
34	Quý vị hoặc bạn tình của mình có sử dụng bao cao su trong lần quan hệ tình dục gần đây nhất không? *She/he or partner used a condom the last time they had sex?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
35	Quý vị có bất cứ câu hỏi nào về khuynh hướng tình dục của mình (người mà quý vị bị thu hút) hoặc nhận dạng giới tính (quý vị cảm thấy mình là con trai, con gái, hoặc giới tính khác) không? *Any questions about sexual orientation or gender identity?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
36	Quý vị có thắc mắc hay lo lắng nào khác về sức khỏe của mình không? *Any other questions or concerns about health?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Other Questions

Nếu có, vui lòng mô tả:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Alcohol, Tobacco, Drug Use	☐	☐	☐	☐	
☐ Sexual Issues	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

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PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Staying Healthy Assessment

Adult

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: ☐ **(men)** 5 or more alcohol drinks in one day? ☐ **(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:

Evaluación de Salud

(Staying Healthy Assessment)

Adulto *(Adult)*

Nombre del paciente (nombre y apellido)	Fecha de nacimiento	☐ Mujer ☐ Hombre	Fecha de hoy
Persona que llena el formulario *(si el paciente necesita ayuda)* ☐ Familiar ☐ Amigo ☐ Otro *Especifique*			¿Necesita ayuda para llenar el formulario? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no sabe una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre alguna sección de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only:
1	¿Bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *Drinks or eats 3 servings of calcium-rich foods daily?*	Sí *Yes*	No	Omitir *Skip*	Nutrition
2	¿Come frutas y verduras todos los días? *Eats fruits and vegetables every day?*	Sí *Yes*	No	Omitir *Skip*	
3	¿Limita la cantidad de alimentos fritos o comida rápida que come? *Limits the amount of fried food or fast food eaten?*	Sí *Yes*	No	Omitir *Skip*	
4	¿Tiene la posibilidad de comer suficientes alimentos saludables? *Easily able to get enough healthy food?*	Sí *Yes*	No	Omitir (Skip)	
5	¿La mayoría de los días bebe un refresco, jugo, bebida deportiva o bebida energizante? *Drinks a soda, juice/sports/energy drink most days of the week?*	No	Sí *Yes*	Omitir *Skip*	
6	Por lo general, ¿come demasiado o muy poco? *Often eats too much or too little food?*	No	Sí *Yes*	Omitir *Skip*	
7	¿Le preocupa su peso? *Concerned about weight?*	No	Sí *Yes*	Omitir *Skip*	
8	¿Hace ejercicio o realiza actividades, como caminar, jardinería o nadar durante, al menos, ½ hora al día? *Exercises or spends time doing moderate activities for at least ½ hour a day?*	Sí *Yes*	No	Omitir *Skip*	Physical Activity
9	¿Se siente seguro donde vive? *Feels safe where she/he lives?*	Sí *Yes*	No	Omitir *Skip*	Safety
10	¿Ha tenido accidentes automovilísticos últimamente? *Had any car accidents lately?*	No	Sí *Yes*	Omitir *Skip*	

11	Durante el último año, ¿alguien lo ha golpeado, abofeteado o lastimado físicamente? *Been hit, slapped, kicked, or physically hurt by someone in the last year?*	No	Sí *Yes*	Omitir *Skip*	
12	¿Siempre usa cinturón de seguridad cuando conduce o viaja en automóvil? *Always wears a seat belt when driving or riding in a car?*	Sí *Yes*	No	Omitir *Skip*	
13	¿Tiene un arma de fuego en su hogar o en el lugar donde vive? *Keeps a gun in house or place where she/he lives?*	No	Sí *Yes*	Omitir *Skip*	
14	¿Se cepilla los dientes y los limpia con hilo dental todos los días? *Brushes and flosses teeth daily?*	Sí *Yes*	No	Omitir *Skip*	Dental Health
15	¿Con frecuencia se siente triste, desesperanzado, enojado o preocupado? *Often feels sad, hopeless, angry, or worried?*	No	Sí *Yes*	Omitir *Skip*	Mental Health
16	¿Con frecuencia tiene dificultades para dormir? *Often has trouble sleeping?*	No	Sí *Yes*	Omitir *Skip*	
17	¿Fuma o masca tabaco? *Smokes or chews tobacco?*	No	Sí *Yes*	Omitir *Skip*	Alcohol, Tobacco, Drug Use
18	¿Sus amigos o familiares fuman en su hogar o en el lugar donde usted vive? *Friends/family members smoke in house or place where she/he lives?*	No	Sí *Yes*	Omitir *Skip*	
19	En el último año ¿ha tomado: ☐ (**hombres**) 5 o más bebidas alcohólicas en un solo día? ☐ (**mujeres**) 4 o más bebidas alcohólicas en un solo día? *In past year, had (5 for men) or (4 for women) or more alcohol drinks in one day?*	No	Sí (Yes)	Omitir *Skip*	
20	¿Consume drogas o medicamentos para ayudarlo a dormir, relajarse, calmarse, sentirse mejor o perder peso? *Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?*	No	Sí *Yes*	Omitir *Skip*	
21	¿Cree que usted o su pareja podría estar embarazada? *Thinks she/he or partner could be pregnant?*	No	Sí *Yes*	Omitir *Skip*	Sexual Issues
22	¿Cree que usted o su pareja pueden tener una infección de transmisión sexual (sexually transmitted infection, STI), como clamidia, gonorrea, verrugas genitales, etc.? *Thinks she/he or partner could have an STI?*	No	Sí *Yes*	Omitir *Skip*	
23	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin utilizar un método anticonceptivo en el último año? *She/he or partner(s) had sex without using birth control in the past year?*	No	Sí *Yes*	Omitir *Skip*	
24	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales con otras personas en el último año? *She/he or partner(s) had sex with other people in the past year?*	No	Sí *Yes*	Omitir *Skip*	

25	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin condón en el último año? *She/he or partner(s) had sex without a condom in the past year?*	No	Sí *Yes*	Omitir *Skip*	
26	¿Alguna vez le forzaron o presionaron para tener relaciones sexuales? *Ever been forced or pressured to have sex?*	No	Sí *Yes*	Omitir *Skip*	
27	¿Tiene alguna otra pregunta o inquietud sobre su salud? *Any other questions or concerns about health?*	No	Sí *Yes*	Omitir *Skip*	Other Questions

Si la respuesta es afirmativa, describa, por favor:

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

保持健康評估

(Staying Healthy Assessment)

成人 *(Adult)*

病人姓名（名和姓）	出生日期	☐女 ☐男	當日日期：
填表人（*如病人需要協助*）	☐家人 ☐朋友 ☐其他 *請註明：*		需要幫助填寫本表格嗎？ ☐是 ☐否

請儘量回答本表格所有的問題。如果您不知道答案或不想回答，請圈選「跳過」。如果對本表格有任何問題，請一定要問醫生。您的回答將與您的醫療記錄一同受到保護。

需要翻譯員嗎？ ☐是 ☐否

					Clinic Use Only:
1	您有沒有每天喝或吃 3 份高鈣食品，例如牛奶、乳酪、優格乳、豆漿或豆腐？ *Drinks or eats 3 servings of calcium-rich foods daily?*	是 *Yes*	否 *No*	跳過 *Skip*	Nutrition
2	您是否每天吃蔬菜水果？ *Eats fruits and vegetables every day?*	是 *Yes*	否 *No*	跳過 *Skip*	
3	您有沒有節制食用油炸食品或快餐的量？ *Limits the amount of fried food or fast food eaten?*	是 *Yes*	否 *No*	跳過 *Skip*	
4	您是否能輕易得到足夠的健康食物？ *Easily able to get enough healthy food?*	是 *Yes*	否 *No*	跳過 *Skip*	
5	您是否每週多日喝蘇打飲料、果汁飲料、運動或能量飲料？ *Drinks a soda, juice/sports/energy drink most days of the week?*	否 *No*	是 *Yes*	跳過 *Skip*	
6	你經常吃過多或過少的食物嗎？ *Often eats too much or too little food?*	否 *No*	是 *Yes*	跳過 *Skip*	
7	您擔心您的體重嗎？ *Concerned about weight?*	否 *No*	是 *Yes*	跳過 *Skip*	
8	您是否每天做半小時的運動或一些如散步、園藝、游泳等的活動？ *Exercises or spends time doing moderate activities for at least ½ hour a day?*	是 *Yes*	否 *No*	跳過 *Skip*	Physical Activity
9	您覺得您住的地方安全嗎？ *Feels safe where she/he lives?*	是 *Yes*	否 *No*	跳過 *Skip*	Safety
10	您最近有沒有出車禍？ *Had any car accidents lately?*	否 *No*	是 *Yes*	跳過 *Skip*	
11	在過去一年中您有沒有被打、打耳光、被踢，或被傷害身體？ *Been hit, slapped, kicked, or physically hurt by someone in the last year?*	否 *No*	是 *Yes*	跳過 *Skip*	

12	您開車或乘車時是否總是繫安全帶？ *Always wears a seat belt when driving or riding in a car?*	是 *Yes*	否 *No*	跳過 *Skip*	
13	您是否在家裡或住處存放槍枝？ *Keeps a gun in house or place where she/he lives?*	否 *No*	是 *Yes*	跳過 *Skip*	
14	您每天都有刷牙和使用牙線嗎？ *Brushes and flosses teeth daily?*	是 *Yes*	否 *No*	跳過 *Skip*	Dental Health
15	你是否經常感到悲傷，絕望，憤怒，或擔心？ *Often feels sad, hopeless, angry, or worried?*	否 *No*	是 *Yes*	跳過 *Skip*	Mental Health
16	您是否經常有睡眠問題？ *Often has trouble sleeping?*	否 *No*	是 *Yes*	跳過 *Skip*	
17	你是否抽煙或嚼煙？ *Smokes or chews tobacco?*	否 *No*	是 *Yes*	跳過 *Skip*	Alcohol, Tobacco, Drug Use
18	是否有朋友或家人在您家或住處抽煙？ *Friends/family members smoke in house or place where she/he lives?*	否 *No*	是 *Yes*	跳過 *Skip*	
19	在過去幾年中，您是否曾： ☐（**男性**）一天內喝 5 或更多杯酒？ ☐（**女性**）一天內喝 4 或更多杯酒？ *In the past year, had (5 for men) or (4 for women) or more alcohol drinks in one day?*	否 *No*	是 *Yes*	跳過 *Skip*	
20	您是否使用任何藥物，幫助您睡眠、放鬆、平靜下來、感覺更好或減肥？ *Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?*	否 *No*	是 *Yes*	跳過 *Skip*	
21	您是否認為您或您的伴侶可能懷孕了？ *Thinks she/he or partner could be pregnant?*	否 *No*	是 *Yes*	跳過 *Skip*	Sexual Issues
22	你是否覺得您或您的伴侶可能得了性傳播感染（STI），如衣原體，淋病，生殖器疣等？ *Thinks she/he or partner could have an STI?*	否 *No*	是 *Yes*	跳過 *Skip*	
23	您或您的伴侶在過去一年中性交時沒有使用避孕方法嗎？ *She/he or partner(s) had sex without using birth control in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	

24	您或您的伴侶在過去一年中曾和其他人發生性關係嗎？ *She/he or partner(s) had sex with other people in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
25	您或您的伴侶在過去一年中性交時沒有使用保險套嗎？ *She/he or partner(s) had sex without a condom in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
26	你有沒有曾被強迫或被施加壓力而發生性關係？ *Ever been forced or pressured to have sex?*	否 *No*	是 *Yes*	跳過 *Skip*	
27	您是否有其他關於您健康上的問題或疑慮？ *Any other questions or concerns about health?*	否 *No*	是 *Yes*	跳過 *Skip*	Other Questions

若回答是，請描述：

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

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PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Đánh Giá về Giữ Gìn Sức Khỏe

(Staying Healthy Assessment)

Người Lớn *(Adult)*

Tên Bệnh Nhân (tên & họ)	Ngày Sinh	☐ Nữ ☐ Nam	Hôm Nay là Ngày
Người Hoàn Thành Mẫu Đơn *(nếu bệnh nhân cần trợ giúp)*	☐ Thành Viên Gia Đình ☐ Bạn Bè ☐ Khác *Vui lòng ghi rõ:*		Cần hỗ trợ điền mẫu? ☐ Có ☐ Không

Vui lòng trả lời tất cả các câu hỏi trong mẫu này một cách tốt nhất có thể. Khoanh tròn "Bỏ Qua" nếu quý vị không biết câu trả lời hoặc không muốn trả lời. Hãy đảm bảo rằng quý vị sẽ hỏi bác sỹ nếu có thắc mắc liên quan đến bất kỳ điều gì trong mẫu này. Tất cả câu trả lời của quý vị sẽ được bảo vệ như một phần hồ sơ y tế của quý vị.

Cần Phiên Dịch? ☐ Có ☐ Không

					Clinic Use Only:
					Nutrition
1	Quý vị có uống hoặc ăn 3 phần thực phẩm giàu canxi chẳng hạn như sữa, pho mát, sữa chua, sữa đậu nành hoặc đậu phụ hàng ngày hay không? *Drinks or eats 3 servings of calcium-rich foods daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
2	Quý vị có ăn trái cây và rau hàng ngày không? *Eats fruits and vegetables every day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
3	Quý vị có giới hạn lượng thức ăn chiên hoặc thức ăn nhanh mà quý vị ăn không? *Limits the amount of fried food or fast food taken?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
4	Quý vị có thể dễ dàng ăn đủ thức ăn có lợi cho sức khỏe không? *Easily able to get enough healthy food?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
5	Quý vị có uống nước xô-đa, nước ép trái cây, đồ uống thể thao hoặc nước tăng lực hầu hết các ngày trong tuần không? *Drinks soda, juice/ sports/ energy drinks most days of the week?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
6	Quý vị có thường ăn quá nhiều hoặc quá ít thức ăn không? *Often eats too much or too little food?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
7	Quý vị có lo lắng về cân nặng của mình hay không? *Concerned about weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
					Physical Activity
8	Quý vị có tập thể dục hoặc dành ½ tiếng một ngày cho các hoạt động như đi bộ, làm vườn, bơi lội không? *Exercises or spends time doing moderate activities for at least ½ hour a day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
					Safety
9	Quý vị có cảm thấy an toàn ở nơi quý vị sống không? *Feels safe where she/he lives?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	

10	Gần đây quý vị có bị tai nạn ô tô nào hay không? *Had any car accidents lately?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
11	Quý vị có bị người nào đánh, bạt tai, đá hay làm bị thương thân thể trong năm vừa qua không? *Been hit, slapped, kicked, or physically hurt by someone in the last year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
12	Quý vị có luôn thắt dây an toàn khi lái xe hoặc đi trên xe không? *Always wears a seat belt when driving or riding in a car?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
13	Quý vị có cất súng trong nhà hoặc nơi ở của mình không? *Keeps a gun in house or place where she/he lives?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
14	Quý vị có đánh răng hay làm sạch kẽ răng của mình hàng ngày hay không? *Brushes and flosses teeth daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Dental Health
15	Quý vị có thường cảm thấy buồn chán, tuyệt vọng, giận dữ hay lo lắng không? *Often feels sad, hopeless, angry, or worried?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Mental Health
16	Quý vị có thường gặp vấn đề về ngủ không? *Often has trouble sleeping?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
17	Quý vị có hút thuốc hay nhai thuốc lá không? *Smokes or chews tobacco?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Alcohol, Tobacco, Drug Use
18	Bạn bè hoặc thành viên gia đình có hút thuốc trong nhà hoặc nơi ở của quý vị không? *Friends/family members smoke in house or place where she/he lives?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
19	Trong năm vừa qua, quý vị có uống: ☐ (**nam giới)** từ 5 ly rượu bia trở lên trong một ngày hay không? ☐ (**phụ nữ**) từ 4 ly rượu bia trở lên trong một ngày hay không? *Had (5 or more for men) or (4 or more for women) alcohol drinks in one day?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
20	Quý vị có sử dụng bất kỳ thuốc hoặc dược phẩm nào giúp quý vị ngủ, thư giãn, bình tĩnh, cảm thấy khỏe hơn hay giảm cân không? *Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
21	Quý vị có nghĩ mình hay bạn tình của mình có thể mang thai không? *Thinks she/he or your partner could be pregnant?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Sexual Issues
22	Quý vị có nghĩ mình hoặc bạn tình của mình có thể mắc bệnh lây nhiễm qua đường tình dục (STI) chẳng hạn như, Chlamydia, Bệnh Lậu, sùi mào gà, v.v… không? *Thinks she/he or partner could have an STI?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	

23	Quý vị hoặc (những) bạn tình của mình có quan hệ tình dục mà không sử dụng biện pháp ngừa thai trong năm vừa qua không? *She/he or partner(s) had sex without using birth control in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
24	Quý vị hay (những) bạn tình của mình có quan hệ tình dục với những người khác trong năm vừa qua không? *She/he or partner(s) has sex with other people in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
25	Quý vị hoặc (những) bạn tình của mình có quan hệ tình dục mà không sử dụng bao cao su trong năm vừa qua không? *She/he or partner(s) had sex without a condom in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
26	Quý vị đã bao giờ bị cưỡng ép hoặc bị áp lực phải quan hê tình dục hay chưa? *Ever been forced or pressured to have sex?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
27	Quý vị có thắc mắc hay lo lắng nào khác về sức khỏe của mình không? *Any other questions or concerns about health?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Other Questions

Nếu có, vui lòng mô tả:

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:

Staying Healthy Assessment

Senior

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	Do you have difficulty chewing or swallowing?	No	Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip	
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?	Yes	No	Skip	Physical Activity
10	Do you feel safe where you live?	Yes	No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?	No	Yes	Skip	
12	Are family members or friends worried about your driving?	No	Yes	Skip	
13	Have you had any car accidents lately?	No	Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?	No	Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?	No	Yes	Skip	
16	Do you keep a gun in your house or place where you live?	No	Yes	Skip	
17	Do you brush and floss your teeth daily?	Yes	No	Skip	Dental Health
18	Do you often feel sad, hopeless, angry, or worried?	No	Yes	Skip	Mental Health
19	Do you often have trouble sleeping?	No	Yes	Skip	
20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	

21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	In the past year, have you had 4 or more alcohol drinks in one day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	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	☐	☐	☐	☐
☐ Independent Living	☐	☐	☐	☐

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:

Evaluación de Salud

(Staying Healthy Assessment)

Personas mayores *(Senior)*

Nombre del paciente (primer nombre y apellido)	Fecha de nacimiento:	☐ Mujer ☐ Hombre	Fecha de hoy
Persona que completa el formulario *(si el paciente necesita ayuda)*	☐ Familiar ☐ Amigo ☐ Otro *Especifique*		¿Necesita ayuda para completar el formulario? ☐ Sí ☐ No

Por favor intente responder todas las preguntas de este formulario lo mejor que pueda. Encierre en un círculo la palabra "Omitir" si no conoce una respuesta o no desea responder. Asegúrese de hablar con el médico si tiene preguntas sobre algún punto de este formulario. Sus respuestas estarán protegidas como parte de su expediente médico.

¿Necesita un intérprete? ☐ Sí ☐ No

					Clinic Use Only:
1	¿Bebe o come 3 porciones al día de alimentos ricos en calcio, como leche, queso, yogur, leche de soja o tofu? *Drinks/eats 3 servings of calcium-rich foods daily?*	Sí *Yes*	No	Omitir *Skip*	Nutrition
2	¿Come frutas y verduras todos los días? *Eats fruits and vegetables every day?*	Sí *Yes*	No	Omitir *Skip*	
3	¿Limita la cantidad de alimentos fritos o comida rápida que come? *Limits the amount of fried food or fast food eaten?*	Sí *Yes*	No	Omitir *Skip*	
4	¿Tiene la posibilidad de comer suficientes alimentos saludables? *Easily able to get enough healthy food?*	Sí *Yes*	No	Omitir *Skip*	
5	¿La mayoría de los días bebe un refresco, jugo, bebida deportiva o bebida energizante? *Drinks a soda, juice/sports/energy drink most days of the week?*	No	Sí *Yes*	Omitir *Skip*	
6	Por lo general, ¿come demasiado o muy poco? *Often eats too much or too little food?*	No	Sí *Yes*	Omitir *Skip*	
7	¿Tiene dificultades para masticar o tragar? *Has difficulty chewing or swallowing?*	No	Sí *Yes*	Omitir *Skip*	
8	¿Le preocupa su peso? *Concerned about weight?*	No	Sí *Yes*	Omitir *Skip*	
9	¿Hace ejercicios o realiza actividades, como caminar, jardinería o nadar durante, al menos, ½ hora al día? *Exercises or spends time doing moderate activities for at least ½ hour a day?*	Sí *Yes*	No	Omitir *Skip*	Physical Activity
10	¿Se siente seguro donde vive? *Feels safe where she/he lives?*	Sí *Yes*	No	Omitir *Skip*	Safety
11	Por lo general, ¿tiene dificultades para llevar un registro de sus medicamentos? *Often has trouble keeping track of medicines?*	No	Sí *Yes*	Omitir *Skip*	

12	¿Sus familiares o amigos se preocupan por la forma en que conduce? *Family members/friends worried about her/his driving?*	No	Sí *Yes*	Omitir *Skip*	
13	¿Ha tenido accidentes automovilísticos últimamente? *Had any car accidents lately?*	No	Sí *Yes*	Omitir *Skip*	
14	¿A veces se cae y se lastima, o le resulta difícil ponerse de pie? *Sometimes falls and hurts self, or has difficulty getting up?*	No	Sí *Yes*	Omitir *Skip*	
15	Durante el último año, ¿alguien lo ha golpeado, abofeteado o lastimado físicamente? *Been hit, slapped, kicked, or physically hurt by someone in past year?*	No	Sí *Yes*	Omitir *Skip*	
16	¿Tiene un revólver en su hogar o en el lugar donde vive? *Keeps a gun in house or place where she/he lives?*	No	Sí *Yes*	Omitir *Skip*	
17	¿Se cepilla los dientes y los limpia con hilo dental todos los días? *Brushes and flosses teeth daily?*	Sí *Yes*	No	Omitir *Skip*	Dental Health
18	¿Con frecuencia se siente triste, desesperanzado, enojado o preocupado? *Often feels sad, hopeless, angry, or worried?*	No	Sí *Yes*	Omitir *Skip*	Mental Health
19	¿Con frecuencia tiene dificultades para dormir? *Often has trouble sleeping?*	No	Sí *Yes*	Omitir *Skip*	
20	¿Usted u otras personas creen que tiene problemas para recordar cosas? *Thinks or others think that she/he is having trouble remembering things?*	No	Sí *Yes*	Omitir *Skip*	
21	¿Fuma o masca tabaco? *Smokes or chews tobacco?*	No	Sí *Yes*	Omitir *Skip*	Alcohol, Tobacco, Drug Use
22	¿Sus amigos o familiares fuman en su hogar o en el lugar donde vive? *Friends/family members smoke in house or place where she/he lives?*	No	Sí *Yes*	Omitir *Skip*	
23	En el último año ¿ha tomado 4 o más bebidas alcohólicas en un solo día? *In the past year, had 4 or more alcohol drinks in one day?*	No	Sí *Yes*	Omitir *Skip*	
24	¿Consume drogas o medicamentos para ayudarlo a dormir, relajarse, calmarse, sentirse mejor o perder peso? *Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?*	No	Sí *Yes*	Omitir *Skip*	
25	¿Cree que usted o su pareja pueden tener una infección de transmisión sexual (sexually transmitted infection, STI), como clamidia, gonorrea, verrugas genitales, etc.? *Thinks she/he or partner could have an STI?*	No	Sí *Yes*	Omitir *Skip*	Sexual Issues

26	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales con otras personas en el último año? *She/he or partner(s) had sex with other people in the past year?*	No	Sí *Yes*	Omitir *Skip*	
27	¿Usted o su(s) pareja(s) tuvieron relaciones sexuales sin condón en el último año? *She/he or your partner(s) had sex without a condom in the past year?*	No	Sí *Yes*	Omitir *Skip*	
28	¿Le han forzado o presionado a tener relaciones sexuales, alguna vez? *Ever been forced or pressured to have sex?*	No	Sí *Yes*	Omitir *Skip*	
29	¿Cuenta con alguien que lo ayude a tomar decisiones sobre su salud o su atención médica? *Has someone to help make decisions about her/his health and medical care?*	Sí *Yes*	No	Omitir *Skip*	Independent Living
30	¿Necesita ayuda para bañarse, comer, caminar, vestirse o ir al baño? *Needs help bathing, eating, walking, dressing, or using the bathroom?*	No	Sí *Yes*	Omitir *Skip*	
31	¿Tiene a quién llamar cuando necesita ayuda en una emergencia? *Has someone to call when she/he needs help in an emergency?*	Sí *Yes*	No	Omitir *Skip*	
32	¿Tiene alguna otra pregunta o inquietud sobre su salud? *Any other questions or concerns about your health?*	No	Sí *Yes*	Omitir *Skip*	Other Questions

Si la respuesta es afirmativa, por favor describa:

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

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

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保持健康評估

(Staying Healthy Assessment)

年長者 *(Senior)*

病人姓名（名和姓）	出生日期	☐ 女 ☐ 男	當日日期：
填表人（*如病人需要協助*）	☐家人☐朋友☐其他 *請註明：*		需要幫助填寫本表格嗎？ ☐是☐否

請儘量回答本表格所有的問題。如果您不知道答案或不想回答，請圈選「跳過」。如果對本表格有任何問題，請一定要問醫生。您的回答將與您的醫療記錄一同受到保護。

需要翻譯員嗎？
☐是☐否

					Clinic Use Only:
					Nutrition
1	您有沒有每天喝或吃 3 份高鈣食品，例如牛奶、乳酪、優格乳、豆漿或豆腐？ *Drinks/eats 3 servings of calcium-rich foods daily?*	是 *Yes*	否 *No*	跳過 *Skip*	
2	您是否每天吃蔬菜水果？ *Eats fruits and vegetables every day?*	是 *Yes*	否 *No*	跳過 *Skip*	
3	您有沒有節制食用油炸食品或快餐的量？ *Limits the amount of fried food or fast food eaten?*	是 *Yes*	否 *No*	跳過 *Skip*	
4	您是否能輕易得到足夠的健康食物？ *Easily able to get enough healthy food?*	是 *Yes*	否 *No*	跳過 *Skip*	
5	您是否每週多日喝蘇打飲料、果汁飲料、運動或能量飲料？ *Drinks a soda, juice/sports/energy drink most days of the week?*	否 *No*	是 *Yes*	跳過 *Skip*	
6	你經常吃過多或過少的食物嗎？ *Often eats too much or too little food?*	否 *No*	是 *Yes*	跳過 *Skip*	
7	你是否咀嚼或吞嚥困難？ *Has difficulty chewing or swallowing?*	否 *No*	是 *Yes*	跳過 *Skip*	
8	您擔心您的體重嗎？ *Concerned about weight?*	否 *No*	是 *Yes*	跳過 *Skip*	
9	您是否每天至少做半小時的運動或一些如散步、園藝、游泳等的活動？ *Exercises or spends time doing moderate activities for at least ½ hour a day?*	是 *Yes*	否 *No*	跳過 *Skip*	Physical Activity
10	您覺得您住的地方安全嗎？ *Feels safe where she/he lives?*	是 *Yes*	否 *No*	跳過 *Skip*	Safety
11	您是否經常無法記得您服用的藥物？ *Often has trouble keeping track of medicines?*	否 *No*	是 *Yes*	跳過 *Skip*	

12	家人或朋友是否擔心您駕駛？ *Family members/friends worried about her/his driving?*	否 *No*	是 *Yes*	跳過 *Skip*	
13	您最近有沒有出車禍？ *Had any car accidents lately?*	否 *No*	是 *Yes*	跳過 *Skip*	
14	您是否有時跌倒而導致受傷，或很難起來？ *Sometimes falls and hurts self, or has difficulty getting up?*	否 *No*	是 *Yes*	跳過 *Skip*	
15	在過去一年中您有沒有被打、打耳光、被踢，或被傷害身體？ *Been hit, slapped, kicked, or physically hurt by someone in past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
16	您是否在家裡或住處存放槍枝？ *Keeps a gun in house or place where she/he lives?*	否 *No*	是 *Yes*	跳過 *Skip*	
17	您每天都有刷牙和使用牙線嗎？ *Brushes and flosses teeth daily?*	是 *Yes*	否 *No*	跳過 *Skip*	Dental Health
18	你是否經常感到悲傷，絕望，憤怒，或擔心？ *Often feels sad, hopeless, angry, or worried?*	否 *No*	是 *Yes*	跳過 *Skip*	Mental Health
19	您是否經常有睡眠問題？ *Often has trouble sleeping?*	否 *No*	是 *Yes*	跳過 *Skip*	
20	您或其他人是否認為您記憶有困難？ *Thinks or others think that she/he is having trouble remembering things?*	否 *No*	是 *Yes*	跳過 *Skip*	
21	你是否抽煙或嚼煙？ *Smokes or chews tobacco?*	否 *No*	是 *Yes*	跳過 *Skip*	Alcohol, Tobacco, Drug Use
22	是否有朋友或家人在您家或住處抽煙？ *Friends/family members smoke in house or place where she/he lives?*	否 *No*	是 *Yes*	跳過 *Skip*	
23	在過去幾年中，您是否曾一天內喝4或更多杯酒？ *In the past year, had 4 or more alcohol drinks in one day?*	否 *No*	是 *Yes*	跳過 *Skip*	
24	您是否使用任何藥物，幫助您睡眠、放鬆、平靜下來、感覺更好或減肥？ *Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?*	否 *No*	是 *Yes*	跳過 *Skip*	
25	你是否覺得您或您的伴侶可能得了性傳播感染（STI），如衣原體，淋病，生殖器疣等？ *Thinks she/he or partner could have an STI?*	否 *No*	是 *Yes*	跳過 *Skip*	Sexual Issues

26	您或您的伴侶在過去一年中曾和其他人發生性關係嗎？ *She/he or partner(s) had sex with other people in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
27	您或您的伴侶在過去一年中性交時沒有使用保險套嗎？ *She/he or your partner(s) had sex without a condom in the past year?*	否 *No*	是 *Yes*	跳過 *Skip*	
28	你有沒有曾被強迫或被施加壓力而發生性關係？ *Ever been forced or pressured to have sex?*	否 *No*	是 *Yes*	跳過 *Skip*	
29	有沒有人幫助您決定您的健康和醫療保健？ *Has someone to help make decisions about her/his health and medical care?*	是 *Yes*	否 *No*	跳過 *Skip*	Independent Living
30	您洗澡、吃飯、走路、穿衣或上廁所是否需要幫助？ *Needs help bathing, eating, walking, dressing, or using the bathroom?*	否 *No*	是 *Yes*	跳過 *Skip*	
31	在緊急情況下您需要幫助時，您有沒有可以打電話的人？ *Has someone to call when she/he needs help in an emergency?*	是 *Yes*	否 *No*	跳過 *Skip*	
32	您是否有任何其他關於您健康上的問題或疑慮？ *Any other questions or concerns about health?*	否 *No*	是 *Yes*	跳過 *Skip*	Other Questions

若回答是，請描述：

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

Comments:

☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

SHA ANNUAL REVIEW

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PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:
PCP's Signature:	Print Name:	Date:

Đánh Giá về Giữ Gìn Sức Khỏe

(Staying Healthy Assessment)

Người Cao Tuổi *(Senior)*

Tên Bệnh Nhân (tên & họ)	Ngày Sinh	☐ Nữ ☐ Nam	Hôm Nay là Ngày
Người Hoàn Thành Mẫu Đơn *(nếu bệnh nhân cần trợ giúp)*	☐ Thành Viên Gia Đình ☐ Bạn Bè ☐ Khác *Vui lòng ghi rõ:*		Cần hỗ trợ điền mẫu? ☐ Có ☐ Không

Vui lòng trả lời tất cả các câu hỏi trong mẫu này một cách tốt nhất có thể. Khoanh tròn "Bỏ Qua" nếu quý vị không biết câu trả lời hoặc không muốn trả lời. Hãy đảm bảo rằng quý vị sẽ hỏi bác sỹ nếu có thắc mắc liên quan đến bất kỳ điều gì trong mẫu này. Tất cả câu trả lời của quý vị sẽ được bảo vệ như một phần hồ sơ y tế của quý vị.

Cần Phiên Dịch? ☐ Có ☐ Không

					Clinic Use Only:
					Nutrition
1	Quý vị có uống hoặc ăn 3 phần thực phẩm giàu canxi chẳng hạn như sữa, pho mát, sữa chua, sữa đậu nành hoặc đậu phụ hàng ngày hay không? *Drinks/eats 3 servings of calcium-rich foods daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
2	Quý vị có ăn trái cây và rau hàng ngày không? *Eats fruits and vegetables every day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
3	Quý vị có giới hạn lượng thức ăn chiên hoặc thức ăn nhanh mà quý vị ăn không? *Limits the amount of fried food or fast food eaten?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
4	Quý vị có thể dễ dàng ăn đủ thức ăn có lợi cho sức khỏe không? *Easily able to get enough healthy food?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
5	Quý vị có uống nước xô-đa, nước ép trái cây, đồ uống thể thao hoặc nước tăng lực hầu hết các ngày trong tuần không? *Drinks a soda, juice/sports/ energy drink most day of the week?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
6	Quý vị có thường ăn quá nhiều hoặc quá ít thức ăn không? *Often eats too much or too little food?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
7	Quý vị có gặp khó khăn trong việc nhai hay nuốt không? *Has difficulty chewing or swallowing?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
8	Quý vị có lo lắng về cân nặng của mình hay không? *Concerned about weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
					Physical Activity
9	Quý vị có tập thể dục hoặc dành thời gian cho các hoạt động như đi bộ, làm vườn hay bơi lội ít nhất ½ tiếng một ngày không? *Exercises or spends time doing moderate activities for at least ½ hour a day?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
					Safety
10	Quý vị có cảm thấy an toàn ở nơi quý vị sống không? *Feels safe where she/he lives?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
11	Quý vị có thường gặp vấn đề trong việc theo dõi dược phẩm của mình không? *Often has trouble keeping track of medicines?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	

12	Thành viên gia đình hoặc bạn bè có lo lắng khi quý vị lái xe không? *Family members/friends worried about her/his driving?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
13	Gần đây quý vị có bị tai nạn ô tô nào hay không? *Had any car accidents lately?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
14	Thỉnh thoảng quý vị có bị ngã và tự làm bị thương hoặc thấy khó đứng dậy không? *Sometimes falls and hurts self, or has difficulty getting up?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
15	Quý vị có bị người nào đó đánh, bạt tai, đá hay làm bị thương thân thể trong năm vừa qua không? *Been hit, slapped, kicked, or physically hurt by someone in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
16	Quý vị có cất súng trong nhà hoặc nơi ở của mình không? *Keeps a gun in house/place where she/he lives?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
17	Quý vị có đánh răng hay làm sạch kẽ răng của mình hàng ngày hay không? *Brushes and flosses teeth daily?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Dental Health
18	Quý vị có thường cảm thấy buồn chán, tuyệt vọng, giận dữ hay lo lắng không? *Often feels sad, hopeless , angry, or worried?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Mental Health
19	Quý vị có thường gặp vấn đề về ngủ không? *Often has trouble sleeping?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
20	Quý vị hay những người khác có nghĩ rằng quý vị đang gặp vấn đề về trí nhớ không? *Thinks or others think that she/he is having trouble remembering things?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
21	Quý vị có hút thuốc hay nhai thuốc lá không? *Smokes or chews tobacco?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Alcohol, Tobacco, Drug Use
22	Bạn bè hoặc thành viên trong gia đình có hút thuốc trong nhà hay nơi ở của quý vị không? *Friends/family members smoke in house or place where she/he lives?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
23	Trong năm vừa qua, quý vị có uống từ 4 ly rượu bia trở lên trong một ngày hay không? *In the past year, had 4 or more alcohol drinks in one day?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
24	Quý vị có sử dụng bất kỳ thuốc hoặc dược phẩm nào giúp quý vị ngủ, thư giãn, bình tĩnh, cảm thấy khỏe hơn hay giảm cân không? *Uses any drugs/medicines to help sleep, relax, calm down, feel better, or lose weight?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
25	Quý vị có nghĩ mình hoặc bạn tình của mình có thể mắc bệnh lây nhiễm qua đường tình dục (STI) chẳng hạn như, Chlamydia, Bệnh Lậu, sùi mào gà, v.v… không? *Thinks she/he or partner could have an STI?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Sexual Issues

26	Quý vị hay (những) bạn tình của mình có quan hệ tình dục với những người khác trong năm vừa qua không? *She/he or partner(s) had sex with other people in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
27	Quý vị hoặc (những) bạn tình của mình có quan hệ tình dục mà không sử dụng bao cao su trong năm vừa qua không? *She/he or your partner(s) had sex without a condom in the past year?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
28	Quý vị đã bao giờ bị cưỡng ép hoặc bị áp lực phải quan hệ tình dục hay chưa? *Ever been forced or pressured to have sex?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
29	Có ai giúp quý vị đưa ra quyết định về việc chăm sóc sức khỏe và y tế cho quý vị không? *Has someone to help make decisions about her/his health and medical care?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	Independent Living
30	Quý vị có cần giúp đỡ khi tắm, ăn, đi bộ, mặc quần áo hay sử dụng phòng tắm không? *Needs help bathing, eating, walking, dressing, or using the bathroom?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	
31	Quý vị có người nào đó để gọi khi cần giúp đỡ trong trường hợp khẩn cấp không? *Has someone to call when she/he needs help in an emergency?*	Có *Yes*	Không *No*	Bỏ Qua *Skip*	
32	Quý vị có thắc mắc hay lo lắng nào khác về sức khỏe của mình không? *Any other questions or concerns about your health?*	Không *No*	Có *Yes*	Bỏ Qua *Skip*	Other Questions

Nếu có, vui lòng mô tả:

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

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:

STAYING HEALTHY ASSESSMENT (SHA)

Instruction Sheet for the Provider Office

SHA PERIODICITY TABLE

	Administer	Administer /Re-Administer		Review
Questionnaire Age Groups	Within 120 Days of Enrollment	1st Scheduled Exam *(after entering new age group)*	Every 3-5 Years	Annually *(Intervening Years)*
0 - 6 Mo	√			
7 - 12 Mo	√	√		
1 - 2 Yrs	√	√		√
3 - 4 Yrs	√	√		√
5 - 8 Yrs	√	√		√
9 -11 Yrs	√	√		√
12 - 17 Yrs	√	√		√
Adult	√		√	√
Senior	√		√	√

SHA COMPLETION BY MEMBER

- Explain the SHA's purpose and how it will be used by the PCP.
- Offer SHA translation, interpretation, and accommodation for any disability if needed.
- Assure patient that SHA responses will be kept confidential in patient's medical record, and that patient's has the right to skip any question.
- A parent/guardian must complete the SHA for children under 12.
- Self-completion is the preferred method of administering the SHA because it increases the likely hood of obtaining accurate responses to sensitive or embarrassing questions.
- If preferred by the patients or PCP, the PCP or other clinic staff may verbally asked questions and record responses on the questionnaire or electronic format.

PATIENT REFUSAL TO COMPLETE THE SHA

- How to document the refusal on the SHA:
  1) Enter the patient's name and "date of refusal" on first page
  2) Check the box "SHA Declined by Patient" (last page page)
  3) PCP must sign, print name and date the back page
- Patients who previously refused/declined to complete the SHA should be encouraged to complete an age appropriate SHA questionnaire each subsequent year during scheduled exams.
- PCP must sign, print name and date an age appropriate SHA each subsequent year verifying the patient's continued refusal to complete the SHA.

SHA RECOMMENDATIONS

Adolescents (12-17 Years)

- ☐ Annual re-administration is highly recommended for adolescents due to frequently changing behavioral risk factors for this age group.
- ☐ Adolescents should begin completing the SHA on their own at the age of 12 (without parent/guardian assistance) or at the earliest age possible. The PCP will determine the most appropriate age, based on discussion with the family and the family's ethnic/cultural/community background.

Adults and Seniors

- ☐ The PCP should select the assessment (Adult or Senior) best suited for the patient's health & medical status, e.g., biological age, existing chronic conditions, mobility limitations, etc.
- ☐ Annual re-administration is highly recommended for seniors due to frequently changing risk factors that occur in the senior years.

PCP RESPONSIBILITIES TO PROVIDE ASSISTANCE AND FOLLOW-UP

- PCP must review and discuss newly completed SHA with patient. Other clinic staff may assist if under supervision of the PCP, and if medical issues are referred to the PCP.
- If responses indicate risk factor(s) (boxes checked in the middle column), the PCP should prioritize patient's health education needs and willingness to make life style changes, provide tailored health education counseling, interventions, referral and follow-up.
- Annually, PCP must review & discuss previously completed SHA with patient (intervening years) and provide appropriate counseling and follow-up on patient's risk reduction plans, as needed.

REQUIRED PCP DOCUMENTATION

- PCP must sign, print name and date the newly administered SHA to verify it was reviewed with patient and assistance/follow-up was provided as needed.
- PCP must check appropriate boxes in "Clinical Use Only" section to indicate topics and type of assistance provided to patient (last page).
- For subsequent annual reviews, PCP must sign, print name and date "SHA Annual Review" section (last page) to verify the annual review was conducted and discussed with the patient.
- Signed SHA must be kept in patient's medical record.

OPTIONAL CLINIC USE DOCUMENTATION

- Shaded "Clinic Use Only" sections (right column next to questions) and "Comments" section (last page) may be used by PCP/clinic staff for notation of patient discussion and recommendations.