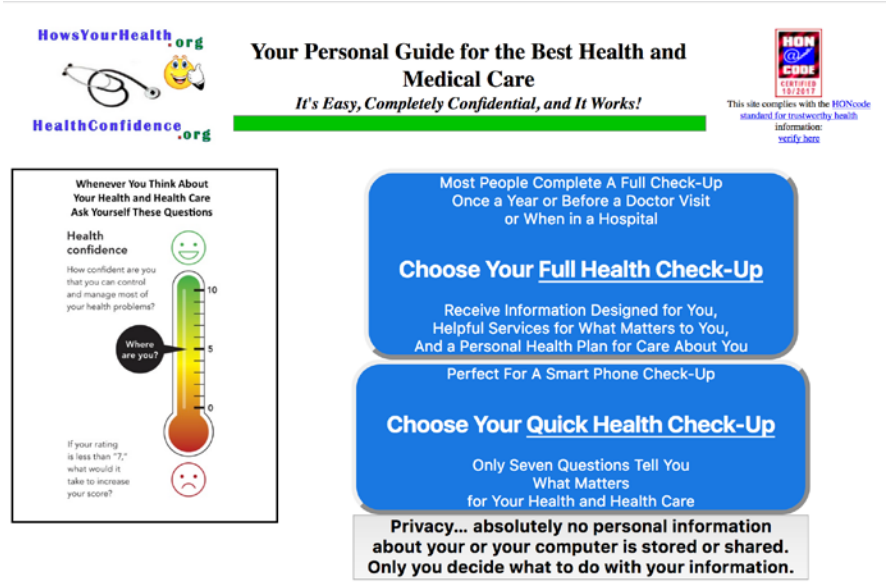


Since 1994, researchers, patients and hundreds of health professionals in the US and Canada have tested and improved HowsYourHealth.org (HYH) so that it attains the listed objectives as efficiently as possible. (Please go the the website for detailed information).

During this period its components have been modified for special circumstances. The next slide lists the attributes of the modifications.

Attributes (and Shortcomings) Of HowsYourHealth.org Modifications

		Fundamental HowsYourHealth Components				
Name or URL	**Modified For**	**Number of Assessment Items**	**Action Package**	**Patient Resources**	**Customization and Improvement Tools**	**Comment (Free except where noted)**
COOP/WONCA Charts	WONCA represents 131 countries and 500,000 physicians; usually administered on paper.	6-9	No	No	No	Multiple Languages; Bristol Myers Squibb provides a free planning kit.
Single Health Confidence		1	No	No	No	
What Matter Index	Screening and Risk Stratification; Good for Smart Phone and Office Vital Signs	5-7	Yes	Limited	No	Directs those who need resources. Paper and Web.
HowsYourHealth.org or HealthConfidence.org	Highly customizable	Varies by needs and demographics for a full health checkup	Yes	Yes	Yes	Web
MedicareHealthAssess.org	AAFP and ACP for Medicare (CMS) Wellness Visit	30 (Not a full health checkup)	Yes	Limited	No	Paper and Web
MedicaidHealthAssess.org	State of Mass Medicaid	Adult Version shortened (30 items) to meet State of Mass Requirement (Not a full health checkup)	No (Mass Only)[1]; Yes (Otherwise)	No (Mass Only)[1]; Limited (Otherwise)	No	Paper and Web
AssessMyHealth	3M Health Systems offers for Medicare and Medicaid	Slightly shortened from full version	Yes	Yes	Limited	Web[1,2]

Footnote: 1. Personal identifier required to access; 2. There is a cost: https://multimedia.3m.com/mws/media/1020967O/3m-assess-my-health-fact-sheet.pdf

Paper versions and Background for MedicareHealthAssess.org

The website includes the Action Form and Related Resources

Information For The Annual Medicare Wellness Visit From the American College of Physicians

http://www.acponline.org/running_practice/practice_management/payment_coding/medicare/annual_wellness_visit.htm

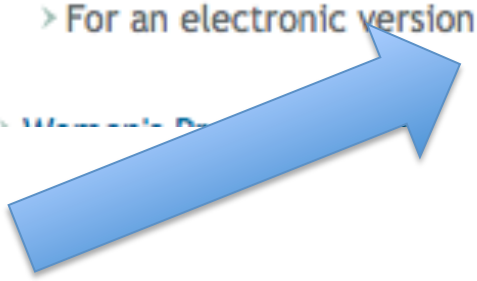
Center for Practice Improvement & Innovation
American College of Physicians

Annual Wellness Visit

- Annual Wellness Visit Benefit Overview
- How to Bill Medicare's Annual Wellness Visit
- AMA's Medicare Preventive Services
- The ABCs of providing the Annual Wellness Visit
- Annual Wellness Visit Brochure for Medicare Providers
- CMS article

The following forms and templates can be customized for use in your practice:

- Practice Checklist
- Patient Letter and Checklist
- Health Risk Assessment
  - For a paper version click here
  - For an electronic version from HowsYourHealth.org, click here



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Family Practice Management

Medicare Annual Wellness Visits: Don't Forget the Health Risk Assessment

Here's one way to meet Medicare's recent addition to the annual wellness visit requirements.

Cindy Hughes, CPC

Published ahead of print on Feb. 14, 2012.

Family Practice Management (*FPM*) published several articles and an encounter form last year related to Medicare's new annual wellness visit (AWV) benefit. Some physicians decided not to offer the AWV due to the complexity of the requirements, but many adapted to Medicare's version of preventive care and provided these visits in 2011. Unfortunately, the requirements for 2012 have changed.

The Affordable Care Act directed the Centers for Medicare & Medicaid Services (CMS) to require that a health risk assessment (HRA) be completed as part of the Medicare AWV. Efforts by the American Academy of Family Physicians and others to persuade CMS to delay the HRA requirement and allow time for physicians and practices to prepare for this change were unsuccessful, and late last year CMS published the final rule making the HRA requirement effective Jan. 1, 2012. The purpose of the HRA, according to CMS, is to help systematize the identification of health behaviors and risk factors such as tobacco use and nutrition that the physician can discuss with the patient in an effort to reduce risk factors and related diseases. The idea is that physicians will use the information from the HRA in developing a personalized prevention plan for the patient.

CMS has not required a specific HRA form. The Centers for Disease Control and Prevention developed a "framework" for the HRA, which was published in a 52-page report in December. The report provides a 6-page example of an HRA, but the example does not contain all of the 34 elements required by CMS in the final rule definition.[1] The HRA must be written at a sixth grade literacy level and be designed so that most

patients can complete it in 20 minutes or less. It doesn't have to be scored.

Compliant HRA tools are presumably being developed by a variety of organizations. One source, HowsYourHealth.org, provides free online assessments that meet the CMS requirements and has developed the paper-based questionnaire published with this article (see "HowsYourHealth.org and the Medicare health risk assessment," below).

So what does this mean to physicians who provide AWVs? Before the face-to-face encounter, your patient needs to complete an HRA. Some patients may need encouragement and assistance from your staff. To compensate for this added staff time, CMS increased the RVUs of the AWV to 4.89 for the initial AWV and 3.26 for the subsequent AWV, thus increasing average reimbursements by an underwhelming $5.39 for the initial and $3.59 for subsequent AWVs.

Other than adding the HRA component, CMS did not change the content of the AWV. Some questions that are required in the HRA are already required elements of the AWV.

Some patients may object to being asked to fill out yet another form; in such cases, your best bet is to document the patient's reasons for not completing the questionnaire and get as much from the visit as you can, keeping in mind that CMS' overarching goal is that Medicare beneficiaries receive a personalized prevention plan. Once a patient has completed the HRA, you need only review and update the answers in subsequent AWVs. After adding an HRA to your process, you can continue to use the FPM encounter form and related articles as references for the rest of the AWV (see "*FPM* Resources for the Medicare annual wellness visit," below).

HowsYourHealth.org and the Medicare health risk assessment

While a number of health risk assessments for the Medicare annual wellness visit may be in development, *FPM* is aware of only one source so far. HowsYourHealth.org, a not-for-profit service of the Dartmouth Co-Op Project, offers two interactive questionnaires that meet the requirements for the AWV:

A brief questionnaire (available at http://www.medicarehealthassess.org) simply asks the required questions and summarizes the results for the practice as a personalized action plan for the patient. It takes less than 10 minutes to complete. Practices may refer their Medicare patients to the new site and ask them to print out the summary action plan before their wellness visit. The questionnaire is also available for download (2-page PDF file; About PDFs).

A longer questionnaire (available at http://www.medicarehealthassess.org and at http://www.howsyourhealth.org) offers a more comprehensive health checkup. This comprehensive HowsYourHealth survey adds to the required items of the AWV a full assessment of the patient's problems and priorities ("what is the matter" and "what matters"). It requires more time to complete, but it also offers more information to patients and practices. It is available for patients of all ages.

There is no charge for the use of either questionnaire, although practices that wish to take advantage of available enhancements to the longer-form questionnaire are asked to pay a fee to help support the HowsYourHealth.org website. According to John Wasson, MD, who supervises both websites within HowsYourHealth, a practice can customize the assessment, receive real-time aggregate information about its patients' needs and experiences of care, and use a patient-loaded registry. Practices who choose to customize HowsYourHealth.org for patients of all ages may test the tool on as many as 50 patients without charge. If satisfied with the results of testing, practices are asked to pay a fee of $350 per year for up to 10 clinicians to support the maintenance and further development of the tools.

FPM Resources for the Medicare Annual Wellness Visit

"What You Need to Know About the Medicare Preventive Services Expansion." Hughes C. January/February 2011:22-25. This article features an annual wellness visit encounter form (6-page PDF file; About PDFs).

"Answers to Your Questions About Medicare Annual Wellness Visits." Hughes C. March/April 2011:13-15.

"Medicare Annual Wellness Visits Made Easier." Hughes C. July/August 2011:10-14.

Reference

1. Medicare Program; Payment Policies Under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition, and Other Revisions to Part B for CY 2012. Fed Regist. 2011;76(228):73306. http://www.gpo.gov/fdsys/pkg/FR-2011-11-28/pdf/2011-28597.pdf. Accessed Feb. 14, 2012.

Send comments to fpmedit@aafp.org.

About the Author

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PAPER MEDICARE WELLNESS SURVEY

MEDICARE WELLNESS CHECKUP

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

Your name: _____

_____

Today's date: _____

Your date of birth: _____

1. What is your age?

☐ 65-69. ☐ 70-79. ☐ 80 or older.

2. Are you a female or a male?

☐ Male. ☐ Female.

3. During the **past four weeks,** how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

4. During the **past four weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

5. During the **past four weeks**, how much bodily pain have you generally had?

☐ No pain.
☐ Very mild pain.
☐ Mild pain.
☐ Moderate pain.
☐ Severe pain.

6. During the **past four weeks**, was someone available to help you if you needed and wanted help?

(For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

☐ Yes, as much as I wanted.
☐ Yes, quite a bit.
☐ Yes, some.
☐ Yes, a little.
☐ No, not at all.

7. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

☐ Very heavy.
☐ Heavy.
☐ Moderate.
☐ Light.
☐ Very light.

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?)

☐ Yes. ☐ No.

9. Can you go shopping for groceries or clothes without someone's help?

☐ Yes. ☐ No.

10. Can you prepare your own meals?

☐ Yes. ☐ No.

11. Can you do your housework without help?

☐ Yes. ☐ No.

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?

☐ Yes. ☐ No.

13. Can you handle your own money without help?

☐ Yes. ☐ No.

14. During the **past four weeks**, how would you rate your health in general?

☐ Excellent.
☐ Very good.
☐ Good.
☐ Fair.
☐ Poor.

continued ➤

15. How have things been going for you during the **past four weeks**?

- ☐ Very well; could hardly be better.
- ☐ Pretty well.
- ☐ Good and bad parts about equal.
- ☐ Pretty bad.
- ☐ Very bad; could hardly be worse.

16. Are you having difficulties driving your car?

- ☐ Yes, often.
- ☐ Sometimes.
- ☐ No.
- ☐ Not applicable, I do not use a car.

17. Do you always fasten your seat belt when you are in a car?

- ☐ Yes, usually.
- ☐ Yes, sometimes.
- ☐ No.

18. How often during the **past four weeks** have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up.	☐	☐	☐	☐	☐
Sexual problems.	☐	☐	☐	☐	☐
Trouble eating well.	☐	☐	☐	☐	☐
Teeth or denture problems.	☐	☐	☐	☐	☐
Problems using the telephone.	☐	☐	☐	☐	☐
Tiredness or fatigue.	☐	☐	☐	☐	☐

19. Have you fallen two or more times in **the past year**?

☐ Yes. ☐ No.

20. Are you afraid of falling?

☐ Yes. ☐ No.

21. Are you a smoker?

- ☐ No.
- ☐ Yes, and I might quit.
- ☐ Yes, but I'm not ready to quit.

22. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

- ☐ 10 or more drinks per week.
- ☐ 6-9 drinks per week.
- ☐ 2-5 drinks per week.
- ☐ One drink or less per week.
- ☐ No alcohol at all.

23. Do you exercise for about 20 minutes three or more days a week?

- ☐ Yes, most of the time.
- ☐ Yes, some of the time.
- ☐ No, I usually do not exercise this much.

24. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

☐ Yes. ☐ No.

Keeping track of your medications?

☐ Yes. ☐ No.

25. How often do you have trouble taking medicines the way you have been told to take them?

- ☐ I do not have to take medicine.
- ☐ I always take them as prescribed.
- ☐ Sometimes I take them as prescribed.
- ☐ I seldom take them as prescribed.

26. How confident are you that you can control and manage most of your health problems?

- ☐ Very confident.
- ☐ Somewhat confident.
- ☐ Not very confident.
- ☐ I do not have any health problems.

27. What is your race? (**Check all that apply.**)

- ☐ White.
- ☐ Black or African American.
- ☐ Asian.
- ☐ Native Hawaiian or Other Pacific Islander.
- ☐ American Indian or Alaskan Native.
- ☐ Hispanic or Latino origin or descent.
- ☐ Other.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Family Practice Management®

SAMPLE OUTPUT FROM MEDICAREHEALTHASSESS.ORG

Short Medicare Action and Planning Form

Print this action form and take it to your doctor to improve the medical care you receive. This form is intended for your doctor or nurse.

Your (Patient) Name:_____

Date: **2012-02-03** Age: **70-79** Gender: **Female**

PATIENT ASSETS

FUNCTION	HABITS	KNOWLEDGE
Social Support - As much as wanted Life is going - Pretty Good	Does not smoke	Home Hazards

PATIENT NEEDS

FUNCTION (*italics = clinician unaware*): *Difficulty with feelings*; Difficulty with pain; Difficulty with physical fitness; Difficulty with overall health; doing housework; driving

SYMPTOMS/BOTHERS: Dizziness, Falling; Eating; Teeth, Dental

HABITS: Not Exercising Regularly

RISK CONSIDERATIONS

Risk for Falls: Risk of falls is higher than most.

Confidence to Self-Manage: Not very confident

Medication Misses: Sometimes I take as prescribed

Seat Belt: Sometimes does not use

SUGGESTED READING AND EDUCATION

- Risks: What Are My Chances? [risk.html]
- Exercise and Eating Well [http://howsyourhealth.org/adult/chapters/chapter1]
- Health Habits and Health Decisions [http://howsyourhealth.org/adult/chapters/chapter2]
- Common Medical Conditions [http://howsyourhealth.org/adult/chapters/chapter4]
- Daily Activities and Managing Limitations [http://howsyourhealth.org/adult/chapters/chapter7]
- Feeling and Emotional Care [http://howsyourhealth.org/adult/chapters/chapter8]
- Pain [http://howsyourhealth.org/adult/chapters/chapter9]

Planning With Health Professionals (During Visit)

ALLERGIES:

CURRENT MEDICATIONS:

IF SICK, WHO DECIDES:

ADDITIONAL PLAN FOR HEALTH CHANGES:
___ See Above Only ___See Below ___ From Problem Solving

Additional Change:
Goal:
Steps:
Barriers to Steps:
Ways to Overcome:
Confidence (0-10):
Help Needed:

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CARE Vital Signs Supports Patient-Centered, Collaborative Care

John H. Wasson, MD; Steve Bartels, MD

Abstract: CARE Vital Signs refers to a standard form created by practices to *C*heck what matters to patients, *A*ct on that assessment, *R*einforce the actions, and systematically *E*ngineer or incorporate actions into staff roles and clinical processes. On its face, CARE Vital Signs is a deceptively simple tool that, when properly used, can help a practice attain levels of efficiency and quality. This article describes the rationale for CARE Vital Signs and the ways it can be used for the greatest benefit.
Key words: *behavior change*, *care team*, *collaborative care*, *patient centered*

IN CLINICAL PRACTICE, someone obtains vital signs, such as blood pressure, pulse, temperature, and respiration rate, to assess body functions before the patient is evaluated by a healthcare professional. CARE Vital Signs refers to a standard form created by practices to *C*heck what matters to patients, *A*ct on that assessment, *R*einforce the actions, and systematically *E*ngineer or incorporate actions into staff roles and clinical processes (Wasson et al., 2003). Thus, CARE Vital Signs offers a method for practices to routinely screen patients to determine whether they have common, important issues for which effective actions might be implemented without necessarily depending on an evaluation by a healthcare professional. For example, based on particular items in CARE Vital Signs, office staff might implement standing orders to provide specific screening tests or self-management education to the patient.

CARE Vital Signs has proven to be useful for both patients and practices. Patients benefit because this method offers the promise of reliable action for "what matters" to them: CARE Vital Signs supports patient-centered, collaborative care (Moore & Wasson, 2006). Practices benefit from using this approach in 2 ways. First, doctors and nurses find that knowing "what matters" to patients improves the efficiency and effectiveness of the care they deliver. For example, the presence of pain and emotional problems adversely impacts patient confidence with self-management, which, in turn, undermines the proven power of collaborative care (Wagner et al., 1996; Wasson et al., 2006b, 2008b). Second, as practices incorporate CARE Vital Signs, the professional and nonprofessional staff invariably uncover inefficient, behaviorally unsophisticated processes and invent better processes and means of deploying the practice's workforce. For example, instead of relying only on the physician, a medical assistant can be trained to help patients use valuable self-management resources for particular issues identified by CARE Vital Signs (Wasson et al., 2003).

From the Centers for Health and Aging, Dartmouth Medical School, Lebanon, NH.

The authors thank the helpful support of the Commonwealth Fund.

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Appendix 3

Geriatric Care Vital Signs

Patient Self-Assessment

Today's date _____

Name _____

1. What questions or concerns do you wish to discuss?
   (please state in the space provided)

_____

_____

2. Pain score _____ (*see below*)
3. Feeling score _____ (*see below*)
4. Social support score _____ (*see below*)
5. Do you often have trouble eating well? *(circle one)*
   Yes, often Yes, sometimes No, never
6. Do you often have trouble remembering or thinking clearly? *(circle one)*
   Yes, often Yes, sometimes No, never
7. Do you often have trouble with dizziness or falls? *(circle one)*
   Yes, often Yes, sometimes No, never
8. Are your pills making you ill? *(circle one)*
   Yes No Maybe Not applicable
9. Are you confident in managing your health problems? *(circle one)*
   Yes No Maybe Not applicable
10. How do you rate your health in general? _____ (*see below*)

Thank you.

Pain

During the past 4 weeks ...
How much bodily pain have you generally had?

No, pain		1
Very mild pain		2
Mild pain		3
Moderate pain		4
Severe pain		5

Feelings

During the past 4 weeks ...
How much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, or downhearted and blue?

Not at all		1
Slightly		2
Moderately		3
Quite a bit		4
Extremely		5

Social support

During the past 4 weeks ...
Was someone available to help you if you needed and wanted help? For example, if you
—felt very nervous, lonely, or blue
—got sick and had to stay in bed
—needed someone to talk to
—needed help with daily chores
—needed help just taking care of yourself

Yes, as much as I wanted		1
Yes, quite a bit		2
Yes, some		3
Yes, a little		4
No, not at all		5

Overall health

During the past 4 weeks...
How would you rate your health in general?

Excellent		1
Very good		2
Good		3
Fair		4
Poor		5

Appendix Figure 3. Copyright © 1995–2008 Centers for Health and Aging at Dartmouth; and Trustees of Dartmouth College and FNX Corporation.

The analysis is based on 3500 responses of patients 70 years or older to the www.HowsYour Health.org Web-based survey tool.

In a majority of practices, about 40% of the patients older than 70 will have no abnormal responses, 40% will have 1 or 2 abnormal responses, and 20% will have 3 or more. However, if a practice cares for patients with low financial status, the distribution will change dramatically with only 10% having no abnormalities and 60% having 3 or more. Appendix Table 1 provides samples of diagnoses, health habits, symptoms, use of assistive devices, and instrumental activities of daily living. Also, it provides days sick in bed and previous use of the hospital. Not surprisingly, every sample marker of illness increases with the number of abnormal Geriatric CARE Vital Signs.

Appendix Table 2 illustrates the quality of care for patients who have adequate finances on the basis of abnormalities on Geriatric CARE Vital Signs. The greater the number of abnormalities, the worse is the perception of care.

ILLUSTRATIVE *ACTIONS* THAT MIGHT BE TAKEN AFTER USING GERIATRIC CARE VITAL SIGNS

Low-needs patients

Patients whose Geriatric Vital Signs have no abnormalities are very low needs patients. Although some of them have chronic diseases, they are confident in self-management and have no pain or emotional problems that will impede their ability to manage their concerns (Wasson et al., 2008a). Except for the smokers among them, the vast majority will also have about a 5 years' longer life expectancy than average for their age (Welch et al., 1996).

A clinician's job is to reassure patients of their good health status, reinforce healthy behaviors, and provide proven preventive care after informing them of their likely life expectancy. The patients should also be encouraged to continue their self-management activities by performing a health check-up annually on-line by using free, noncommercial tools such as HowsYourHealth.org. If this survey tool is used, its registry function can be used to remind them every year to complete the HowsYourHealth.org tool to make sure that they are continuing to do well. They should also be reminded to complete or update an advanced care plan.

Medium-needs patients

These patients have 1 to 2 abnormal responses to the Geriatric CARE Vital Signs. Appendix Table 3 illustrates the types of action an office might consider. (Similar lists of actions generated by expert panels are available elsewhere) (Wenger et al., 2007).

Within this category, the office staff can describe explicit actions and "standing orders" for each of the responses. Many of these actions need not be executed by a physician. In addition, group visits are a very useful enhancement for the typical office visit of a patient who has a few CARE Vital Sign problems.

Because these patients have so many other issues, a comprehensive tool such as HowsYourHealth.org might be used before the next office visit to tailor information for their need and help the clinical staff find out "what matters" to these patients. Patients with medium or high needs will often require family members assist them with the use of computers.

Appendix Table 1. A sample of patient characteristics by category of Geriatric CARE Vital Sign*

Sample patient characteristic	Abnormal Geriatric CARE Vital Signs		
	No abnormalities	1–2 abnormalities	≥3 abnormalities
Medications			
>5 medications	15	28	48
Common diagnoses			
Hypertension	41	54	61
Arthritis	34	51	63
Atherosclerotic cardiovascular disease (any manifestation)	17	26	36
Atherosclerotic cardiovascular disease (congestive heart failure)	3	6	13
Diabetes	10	16	31
Respiratory	10	15	26
Health habits			
Smoker	22	22	30
Not exercising >3 d/wk	37	49	79
Common symptoms			
Wetting	3	8	24
Constipation	4	7	23
Sleeping problems	7	16	36
Instrumental activities of daily living limits			
Cannot get out of the house without help	2	8	30
Cannot handle finances	2	7	18
Impact on life			
Using cane or wheelchair	5	19	40
Confined to bed in last 3 mo	9	15	37
Hospitalized in past year	14	22	39
Quality of life "bad"	0	2	25
Harmed by healthcare in past year	1	2	4
From CARE Vital Signs			
Not confident	0	62	88
Pain	0	30	70
Overall health fair or poor	0	15	72
Pills perhaps causing illness	0	17	54
Lacking social support	0	17	36
Emotional problems	0	5	41
Problems thinking	0	9	37
Dizzy or falling	0	3	23
Eating/nutrition problems	0	1	21

*Values given are in percentages.

High-needs patients

This group of patients represents a rather frail group of elderly patients. They invariably require many services and are at high risk for death, rehospitalizations, and harms associated with healthcare. However, despite their illness burden, about 1 in 4 do not have a clear idea about who will make decisions for them if they become too sick to speak for themselves. They also tend to overestimate their likelihood of survival.

Appendix Table 2. Quality of care reported for 70 years or older patients with adequate financial status*

Quality indicators	Abnormal Geriatric Vital Signs		
	No abnormalities	1–2 abnormalities	≥3 abnormalities
Information and assistance			
Excellent information about chronic disease(s)	50	28	15
Helped live with their problem(s)	59	53	32
Care processes			
Very easy access to needed medical care	62	47	25
Office is efficient: My time is not wasted	87	82	69
Relationship with clinicians			
I have a personal clinician	91	90	91
I have 2 or more clinicians	37	61	66
I know who is in charge	89	88	80

*Values given are in percentages.

Many of these patients will benefit from the same approaches suggested for medium-needs patients. Given these patients multiple needs, it is imperative that family members, the patient, and other providers are all on the "same page" about management issues, priorities, and goals. The special survey within www.howsyourhealth for frail patients may be invaluable for assessing their needs and providing basic education based on their needs. The tool can save much clinician time and help the family and the patient be sure they are on the "same page."

Appendix Table 3. Initial actions for abnormal Geriatric CARE Vital Signs responses

Problems from Geriatric CARE Vital Signs	Initial actions*
Not confident	1. Review understanding of confidence 2. Identify what things patients feel least confident about and why 3. Begin "campaign for confidence"
Pain	1. Source and nature of pain 2. Problem-solving strategies 3. Medication management
Overall health fair or poor	1. Reconfirm rating with patient 2. Use for "decision making in the gray" 3. Use to trigger reminder for advance care planning 4. For those who have fair or poor health have someone help them complete the special HowsYourHealth.org tool for the "very sick or frail"
Pills perhaps causing illness	1. Which pills? 2. How are they "causing illness"? 3. Impact on patient "compliance" with pill taking 4. Explore possible alternatives

(*continues*)

Appendix Table 3. Initial actions for abnormal Geriatric CARE Vital Signs responses (*Continued*)

Problems from Geriatric CARE Vital Signs	Initial actions*
Lacking social support	1. Why the response? 2. What is needed? 3. What is lacking? 4. Problem solving 5. Possible referral
Emotional problems	1. Source and nature of emotional problem 2. Problem-solving strategies 3. Medication management
Problems thinking	1. Why the response? 2. Mini-Mental State Examination or MiniCog 3. Review options based on results
Dizzy or falling	1. Explore nature of problem 2. Get up and go 3. Orthostatic blood pressure 4. Evaluate as needed with particular focus on medications
Eating/nutrition problems	1. Explore nature of the problem 2. Weight and body mass index 3. Evaluate as needed

*For more details on these initial generic solutions, refer to "Activation of Patients for Successful Self-management." Several tools are available at www.howsyourhealth.org.

If possible, the office should designate someone to look out for high-needs patients and coordinate their care. Most importantly, this member of the staff should continuously provide brief proactive reinforcement of self-management and monitoring of important health concerns by phone, if possible, or at every visit.

MEDICARE WELLNESS CHECKUP

Please complete this checklist before seeing your doctor or nurse. Your responses will help you receive the best health and health care possible.

Your name: _____

Most respondents from CA, FL, GA, MI, NC, OH, OK, SC, WI

Today's date: _____

Your date of birth: _____

1. What is your age?

☐ 65-69. ☐ 70-79. ☐ 80 or older.

75% 15% 10%

2. Are you a female or a male?

☐ Male. ☐ Female.

51% 49%

*3. During the **past four weeks,** how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

5% (aware 25%)

*4. During the **past four weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

☐ Not at all.
☐ Slightly.
☐ Moderately.
☐ Quite a bit.
☐ Extremely.

5% (aware 30%)

*5. During the **past four weeks**, how much bodily pain have you generally had?

☐ No pain.
☐ Very mild pain.
☐ Mild pain.
☐ Moderate pain.
☐ Severe pain.

15% (aware 65)

*6. During the **past four weeks**, was someone available to help you if you needed and wanted help?

(For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

☐ Yes, as much as I wanted.
☐ Yes, quite a bit.
☐ Yes, some.
☐ Yes, a little.
☐ No, not at all.

15% (aware 35%)

*7. During the **past four weeks**, what was the hardest physical activity you could do for at least two minutes?

☐ Very heavy.
☐ Heavy.
☐ Moderate.
☐ Light.
☐ Very light.

20% (45% aware)

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?)

☐ Yes. ☐ No.

15%

9. Can you go shopping for groceries or clothes without someone's help?

☐ Yes. ☐ No.

10%

10. Can you prepare your own meals?

☐ Yes. ☐ No.

10%

11. Can you do your housework without help?

☐ Yes. ☐ No.

20%

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?

☐ Yes. ☐ No.

25%

13. Can you handle your own money without help?

☐ Yes. ☐ No.

10%

14. During the **past four weeks**, how would you rate your health in general?

☐ Excellent.
☐ Very good.
☐ Good.
☐ Fair.
☐ Poor.

15%

continued ➤

* if the worse two categories of function, is doctor or nurse aware of the dysfunction? (asked on short internet)

15. How have things been going for you during the **past four weeks**?

- ☐ Very well; could hardly be better. 30%
- ☐ Pretty well.
- ☐ Good and bad parts about equal.
- ☐ Pretty bad.
- ☐ Very bad; could hardly be worse. 5%

16. Are you having difficulties driving your car?

- ☐ Yes, often.
- ☐ Sometimes. 25%
- ☐ No.
- ☐ Not applicable, I do not use a car. 5%

17. Do you always fasten your seat belt when you are in a car?

- ☐ Yes, usually.
- ☐ Yes, sometimes.
- ☐ No. 15%

18. How often during the **past four weeks** have you been *bothered* by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing up.	☐	☐	☐	☐ 5%	☐
Sexual problems.	☐	☐	☐	☐	☐ 10%
Trouble eating well.	☐	☐	☐	☐ 5%	☐
Teeth or denture problems.	☐	☐	☐	☐	☐ 10%
Problems using the telephone.	☐	☐	☐	☐	☐
Tiredness or fatigue.	☐	☐	☐	☐	☐

oops--not programmed on this version

19. Have you fallen two or more times in **the past year**?

20% ☐ Yes. ☐ No.

20. Are you afraid of falling?

30% ☐ Yes. ☐ No.

21. Are you a smoker?

85% ☐ No.
10% ☐ Yes, and I might quit.
5% ☐ Yes, but I'm not ready to quit.

22. During the **past four weeks**, how many drinks of wine, beer, or other alcoholic beverages did you have?

- ☐ 10 or more drinks per week. 10%
- ☐ 6-9 drinks per week.
- ☐ 2-5 drinks per week.
- ☐ One drink or less per week.
- ☐ No alcohol at all. 25%

23. Do you exercise for about 20 minutes three or more days a week?

- ☐ Yes, most of the time. 40%
- ☐ Yes, some of the time.
- ☐ No, I usually do not exercise this much. 35%

24. Have you been given any information to help you with the following:

Hazards in your house that might hurt you?

35% ☐ Yes. ☐ No.

Keeping track of your medications?

45% ☐ Yes. ☐ No.

25. How often do you have trouble taking medicines the way you have been told to take them?

- ☐ I do not have to take medicine. 20%
- ☐ I always take them as prescribed. 55%
- ☐ Sometimes I take them as prescribed.
- ☐ I seldom take them as prescribed. 25%

26. How confident are you that you can control and manage most of your health problems?

- ☐ Very confident. 55%
- ☐ Somewhat confident.
- ☐ Not very confident.
- ☐ I do not have any health problems.

27. What is your race? (**Check all that apply.**)

- ☐ White. 80%
- ☐ Black or African American. 5%
- ☐ Asian. 5%
- ☐ Native Hawaiian or Other Pacific Islander.
- ☐ American Indian or Alaskan Native.
- ☐ Hispanic or Latino origin or descent.
- ☐ Other.

Thank you very much for completing your Medicare Wellness Checkup. Please give the completed checkup to your doctor or nurse.

Family Practice Management®

Survey Items in English and Spanish for MedicaidHealthAssess.org

The website includes the Action Form and Related Resources

Examples of Paper Version in English and Spanish

COMMUNITY CARE COOPERATIVE

How's Your Health - Adult Enrollee Screen

Your Name:_____

Today's Date:_____

Your Date of Birth:_____

PLEASE CIRCLE OR WRITE YOUR ANSWERS

1. Your preferred language is?

   English Espanol Other Language (**Write Below**)

   _____

2. Are you a male or a female?
   Male Female

3. During the **past 4 weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, or sad?

   Not at all.
   Slightly.
   Moderately.
   Quite a bit.
   Extremely.

4. During the **past 4 weeks**, has your physical and emotional health limited your social activities with family friends, neighbors, or groups?

   Not at all.
   Slightly.
   Moderately.
   Quite a bit.
   Extremely.

5. Do you have any concerns about ? (Please mark all that apply.)

   Violence or abuse
   Sexual issues or birth control
   AIDS and other sexually transmitted diseases
   How to make the health care system work better for you
   Substance abuse (beer, wine, drugs)
   Preventing injuries or accidents

6. During the **past 4 weeks**, how much bodily pain have you generally had?

   No pain.
   Very mild pain.
   Mild pain.
   Moderate pain.
   Severe pain.

7. During the **past 4 weeks**, was someone available to help you if you needed and wanted help?

   (For example, if you felt very nervous, lonely, or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)

   Yes, as much as I wanted.
   Yes, quite a bit.
   Yes, some.
   Yes, a little,
   No, not at all.

8. During the **past 4 weeks**, what was the hardest physical activity you could do for at least 2 minutes?

   Very heavy.
   Heavy.
   Moderate.
   Light.
   Very light.

9. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?)
   Yes. No.

10. Can you go shopping for groceries or clothes without someone's help?
    Yes. No.

11. Can you prepare your own meals?
    Yes. No.

12. Can you do your housework without help?
    Yes. No.

13. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?
    Yes. No.

This brief "checkup" is designed to improve your health and health care. With your permission your name and year of birth are used to provide information and services suited to your needs.

14. Can you handle your own money without help?
    Yes. No.

15. Do you have enough money to buy the things you need to live everyday such as food, clothing and housing?

    Yes, Always.
    Sometimes.
    No.

16. Has a doctor told you that you have ANY of these problems?

    High blood pressure
    Heart trouble or hardening of the arteries
    (Sugar) Diabetes
    Arthritis
    Asthma, bronchitis or emphysema
    Mental or emotional problems
    Serious obesity (more than 15% overweight)
    Another problem (**List here**)

    _____

17. How confident are you that you can control and manage most of your health problems?

    Very confident.
    Somewhat confident.
    Not very confident.
    I do not have any health problems.

18. How many different prescription medications are you currently taking more than three days a week?

    None
    1-2
    3-5
    More than 5

19. Do you think that any of your pills are making you sick?

    Yes
    No
    Maybe, I am not sure
    I am not taking any pills

20. Do doctors, nurses, and other health professionals who see you regularly keep good communication and contact with each other?

    Yes, all of the time
    Yes, most of the time
    Some of the time
    A little of the time
    None of the time

21. When you think about your health care, how much do you agree or disagree with this statement:

I receive exactly what I want and need exactly when and how I want and need it.

    Strongly Agree
    Somewhat Agree
    Somewhat Disagree
    Disagree Strongly
    I do not use health

22. Check **ANY** of the services you are receiving now or services you need help with:

Services	I Am Using Now	Need Help With
Housing Help – such as finding or paying for housing		
Utility Help – such as for electricity, gas, telephone, or water		
Nutrition Help – such as home meals or food stamps		
Employment/Job Training Support		
Vision or Hearing Services		
Transportation Help		
Homemaker and Chore Services		
Respite or Day Care Services – for persons who need to be supervised		
Nursing and Home Health Services		
Mental Health or Substance Use Disorder Services		
Physical Therapy or Exercise Help		

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COMMUNITY CARE COOPERATIVE

¿Cómo está su salud? - Evaluación para adulto inscrito

POR FAVOR ESCRIBA O DIBUJE UN CÍRCULO ALREDEDOR DE SU RESPUESTA

Su nombre:_____

Fecha de hoy:_____

Su fecha de nacimiento:_____

1. ¿Cuál es su idioma preferido?
   Inglés Español Otro (**Liste abajo**)

   _____

2. ¿Es usted hombre o mujer?
   Hombre Mujer

3. Durante las **últimas cuatro semanas**, ¿qué tan molesto(a) se ha sentido por problemas emocionales tales como sentirse ansioso(a), deprimido(a), irritable o triste?

   Para nada.
   Un poco.
   Moderadamente.
   Bastante.
   Extremadamente.

4. Durante las **últimas cuatro semanas**, ¿sus actividades sociales con amistades, vecinos, o grupos han sido limitadas debido a su salud física o emocional?

   Para nada.
   Un poco.
   Moderadamente.
   Bastante.
   Extremadamente.

5. ¿Tiene usted alguna inquietud acerca de lo siguiente? (Por favor marque todo lo que aplique.)

   La violencia o abuso
   Asuntos sexuales o la contracepción
   SIDA y otras enfermedades de transmisión sexual
   Qué hacer para que el sistema de servicios de salud funcione mejor para mí
   Abuso de sustancias (cerveza, vino, drogas)
   Prevención de lesiones o accidentes

6. Durante las **últimas cuatro semanas**, ¿cuánto dolor de cuerpo ha tenido, generalmente?

   Ningún dolor.
   Dolor muy leve.
   Dolor leve.
   Dolor moderado.
   Dolor fuerte.

7. Durante las **últimas cuatro semanas**, ¿estuvo alguien disponible para ayudarle si usted necesitó o quiso ayuda?

   (Por ejemplo, si se sintió muy nervioso(a), solo(a), o desalentado(a); se enfermó y tuvo que reposar en cama; necesitó a alguien con quien hablar; necesitó ayuda con los quehaceres diarios; o necesitó ayuda con tan solo cuidarse a usted mismo(a).)

   Sí, tanto como quise.
   Sí, bastante.
   Sí, algo.
   Sí, un poco.
   No, para nada.

8. Durante las **últimas cuatro semanas**, ¿cuál fue la actividad física más difícil que pudo hacer durante dos minutos, por lo menos?

   No, para nada.
   Muy intensa.
   Intensa.
   Moderada.
   Suave.
   Muy suave.

9. ¿Puede usted llegar a sitios lejanos sin ayuda? (Por ejemplo, ¿puede viajar solo(a) en buses o taxis, o conducir su propio vehículo?)
   Sí. No.

10. ¿Puede usted hacer compras de comida o ropa sin la ayuda de otra persona?
    Sí. No.

11. ¿Puede usted preparar su propia comida?
    Sí. No.

12. ¿Puede usted hacer los quehaceres del hogar sin ayuda?
    Sí. No.

13. Debido a cualquier problema de salud, ¿necesita usted la ayuda de otra persona con sus necesidades para el cuidado personal, tales como comer, bañarse, vestirse, o andar dentro del hogar?
    Sí. No.

Este breve "chequeo" está diseñado para mejorar su salud y servicios de salud. Con su permiso su nombre y año de nacimiento se usan para proveer información y servicios adecuados para sus necesidades.

14. ¿Puede usted administrar su propio dinero sin ayuda?
    Sí. No.

15. ¿Tiene usted suficiente dinero para necesidades diarias tales como para la comida, ropa y vivienda?

    Sí, siempre.
    A veces.
    No.

16. ¿Su doctor le ha dicho que usted tiene ALGÚN O ALGUNOS de los siguientes problemas? Marque CUALQUIERA que le aplique.

    Presión arterial alta
    Problemas del corazón o endurecimiento de las arterias
    (Azúcar) Diabetes
    Artritis
    Asma, bronquitis o enfisema
    Problemas mentales o emocionales
    Obesidad grave (más de 15% sobrepeso)
    Otro problema (**Liste aquí**)

    _____

17. ¿Qué tan seguro(a) se siente en controlar y afrontar la mayoría de sus problemas de salud?

    Muy seguro(a).
    Algo seguro(a).
    No muy seguro(a).
    Yo no tengo ningún problema de salud.

18. ¿Cuántos medicamentos recetados está tomando por más de tres días a la semana?

    Ninguno
    1-2
    3-5
    Más de 5

19. ¿Piensa usted que alguna(s) de sus pastillas le están poniendo enfermo(a)?

    Sí
    No
    Tal vez, no estoy seguro(a)
    Yo no estoy tomando ninguna pastilla

20. ¿Los doctores, enfermeros y otros profesionales de la salud quienes le ven regularmente mantienen buena comunicación y contacto entre ellos mismos?

    Sí, todo el tiempo
    Sí, casi todo el tiempo
    Algunas veces
    Pocas veces
    Ni una sola vez

21. Cuando usted considera su servicio de salud, ¿qué tan de acuerdo o desacuerdo está con ésta declaración?:

Yo recibo exactamente lo que quiero y lo que necesito, exactamente cuando y cómo lo quiero y lo necesito.

    Totalmente de acuerdo
    Algo de acuerdo
    Algo en desacuerdo
    Totalmente en desacuerdo
    Yo no uso servicios de salud

22. Marque **CUALQUIERA** de los servicios que actualmente está recibiendo o que necesita:

Servicios	**Recibo Actualmente**	**Necesito Ayuda**
Ayuda con vivienda – tales como encontrar o pagar por vivienda		
Ayuda con servicios públicos – tales como para electricidad, gas, teléfono o agua		
Ayuda con nutrición – tales como entregas de comida a domicilio o cupones de alimentos		
Empleo/Apoyo para entrenamiento laboral		
Servicios para visión o audición		
Ayuda con transporte		
Ayuda domésticos o con los quehaceres del hogar		
Alivio temporario o servicios para centros de cuidado de día– para personas quienes necesitan supervisión		
Enfermería y servicios de asistencia médica a domicilio		
Salud mental o servicios para el trastorno de uso de sustancias		
Fisioterapia o ayuda con ejercicios		

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COMMUNITY CARE COOPERATIVE

How's Your Health –

Adolescent Enrollee Screen

Youth's Name: _____
Today's Date: _____
Youth's Date of Birth: _____

PLEASE "X" OR WRITE YOUR ANSWERS

1. Are you a male or female? Male Female

2. During the past month, how often did you talk about your problems, feelings, or opinions with someone in your family?
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ A little of the time
   - ☐ None of the time

   a. You answered that you rarely or never talked about problems, feelings, or opinions with someone in your family. Have you talked to anyone about a family problem?
      - ☐ Yes
      - ☐ No

   b. You answered that you talked to someone about the family problem. Was what you were told helpful for you?
      - ☐ Extremely
      - ☐ Quite a lot
      - ☐ Moderately
      - ☐ A little
      - ☐ Not at all

   c. You answered that you talked to someone about the family problem. Who were the people you spoke to? (Please mark all that apply.)
      - ☐ Family
      - ☐ Friends
      - ☐ Doctors or nurses
      - ☐ Teachers or school counselors
      - ☐ Others

3. During the past month, how often did you feel anxious, depressed, irritable, or sad?
   - ☐ None of the time
   - ☐ A little of the time
   - ☐ Some of the time
   - ☐ Most of the time
   - ☐ All of the time

   a. You answered that you have been bothered more than average by your feelings. Have you talked to anyone about your feelings?
      - ☐ Yes
      - ☐ No

   b. You answered that you have talked to someone about your feelings.Was what you were told helpful to you?
      - ☐ Extremely
      - ☐ Quite a lot
      - ☐ Moderately
      - ☐ A little
      - ☐ Not at all

   c. You answered that you have talked to someone about your feelings. Who were the people you spoke to? (Please mark all that apply.)
      - ☐ Family
      - ☐ Friends
      - ☐ Doctors or nurses
      - ☐ Teachers or school counselors
      - ☐ Others

4. During the past month, how often did you do things that are harmful to your health such as smoke cigarettes or chew tobacco, have unprotected sex, or use alcohol including beer and wine?
   - ☐ None of the time
   - ☐ A little of the time
   - ☐ Some of the time
   - ☐ Most of the time
   - ☐ All of the time

   a. You answered that you often do things that are harmful to your health. Have you talked to anyone about these things?
      - ☐ Yes
      - ☐ No

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b. You answered that you talked with someone about your harmful health habits. Was what you were told helpful for you?
- ☐ Extremely
- ☐ Quite a lot
- ☐ Moderately
- ☐ A little
- ☐ Not at all

c. You answered that you talked with someone about your harmful health habits. Who were the people you spoke to? (Please mark all that apply.)
- ☐ Family
- ☐ Friends
- ☐ Doctors or nurses
- ☐ Teachers or school counselors
- ☐ Others

5. During the past month, how often were you bothered by pains such as backaches, headaches, cramps or stomach aches?
- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

a. You answered that you are bothered by bodily pain. Have you talked to anyone about your pain?
- ☐ Yes
- ☐ No

b. You answered that you talked to someone about your bodily pain. Was what you were told helpful for you?
- ☐ Extremely
- ☐ Quite a lot
- ☐ Moderately
- ☐ A little
- ☐ Not at all

c. You answered that you have been bothered by bodily pain. Who were the people you spoke to? (Please mark all that apply.)
- ☐ Family
- ☐ Friends
- ☐ Doctors or nurses
- ☐ Teachers or school counselors
- ☐ Others

6. During the past month, if you needed someone to listen or to help you, was someone there for you?
- ☐ Yes, as much as I wanted
- ☐ Yes, quite a bit
- ☐ Yes, some
- ☐ Yes, a little
- ☐ No, not at all

a. You answered that you had very little or no social support. Have you talked to anyone about this problem?
- ☐ Yes
- ☐ No

b. You answered that you talked to someone about your social support. Was what you were told helpful for you?
- ☐ Extremely
- ☐ Quite a lot
- ☐ Moderately
- ☐ A little
- ☐ Not at all

c. You answered that you had very little or no social support. Who were the people you spoke to? (Please mark all that apply.)
- ☐ Family
- ☐ Friends
- ☐ Doctors or nurses
- ☐ Teachers or school counselors
- ☐ Others

7. During the past month, what was the hardest physical activity you could do for at least 10 minutes?
- ☐ Very heavy
- ☐ Heavy
- ☐ Moderate
- ☐ Light
- ☐ Very light

a. You answered that you have difficulty doing physical activities. Have you talked to anyone about your physical fitness?
- ☐ Yes
- ☐ No

b. You answered that you talked to someone about your physical fitness. Was what you were told helpful for you?
   - ☐ Extremely
   - ☐ Quite a lot
   - ☐ Moderately
   - ☐ A little
   - ☐ Not at all

c. You answered that you talked to someone about your physical fitness.Who were the people you spoke to? (Please mark all that apply.)
   - ☐ Family
   - ☐ Friends
   - ☐ Doctors or nurses
   - ☐ Teachers or school counselors
   - ☐ Others

8. During the last month you were in school, how did you do?
   - ☐ I did very well
   - ☐ I did as well as I could
   - ☐ I could have done a little better
   - ☐ I could have done much better
   - ☐ I did poorly

a. You answered that you could have done better in school. Have you talked to anyone about your school work?
   - ☐ Yes
   - ☐ No

b. You answered that you had talked to someone about your school work. Was what you were told helpful for you?
   - ☐ Extremely
   - ☐ Quite a lot
   - ☐ Moderately
   - ☐ A little
   - ☐ Not at all

c. You answered that you had talked to someone about your school work. Who were the people you spoke to? (Please mark all that apply.)
   - ☐ Family
   - ☐ Friends
   - ☐ Doctors or nurses
   - ☐ Teachers or school counselors
   - ☐ Others

9. How often do you practice good health habits in two or more of the following areas: using a seat belt, getting exercise, eating right, getting enough sleep, or wearing safety helmets?
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ A little of the time
   - ☐ None of the time

10. The following "shots" (immunizations) are helpful to prevent bad diseases. Have you had them?

	Yes	No	I am not sure
Measles, mumps, rubella (MMR)	☐	☐	☐
Tetanus in the past 10 years	☐	☐	☐
Hepatitis B shot	☐	☐	☐
Chicken pox (varicella)	☐	☐	☐
HPV Vaccine (Human papilloma	☐	☐	☐

☐

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11. How often during the PAST FOUR WEEKS have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Headache	☐	☐	☐	☐	☐
Stomach pains	☐	☐	☐	☐	☐
Dizzy spells, tiredness or fatigue	☐	☐	☐	☐	☐
Chest pains	☐	☐	☐	☐	☐
Menstrual problems	☐	☐	☐	☐	☐
Eating or weight problems	☐	☐	☐	☐	☐

12.How often during the PAST FOUR WEEKS have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Skin problems	☐	☐	☐	☐	☐
Sexual problems	☐	☐	☐	☐	☐
Asthma or breathing problems	☐	☐	☐	☐	☐
Trouble paying attention	☐	☐	☐	☐	☐
Trouble solving problems	☐	☐	☐	☐	☐

13, Do you have any concerns about? (Please mark all that apply.)

- ☐ Violence or abuse
- ☐ Sexual issues or birth control
- ☐ AIDS and other sexually transmitted diseases
- ☐ Depression and suicide
- ☐ Substance abuse (beer, wine, drugs)
- ☐ Exercise needs
- ☐ Nutrition, eating disorders
- ☐ Access to food
- ☐ Access to stable, healthy housing
- ☐ Loss of heat, electricity, water, or telephone service in your home
- ☐ Challenges getting to or from school
- ☐ Summer job opportunities
- ☐ Classes for English Language Learners

14. In the last year, have you seen: (Please mark all that apply.)

- ☐ A dentist
- ☐ An eye doctor
- ☐ A counselor or psychologist
- ☐ Another doctor

15. Do you have any of the following? (Mark all that apply.)

- ☐ Asthma
- ☐ Another disease
- ☐ Obesity (more than 15% overweight)

a. If you indicated that you have asthma or a breathing problem, how would you rate the information your doctor or a nurse gave you about:

	Excellent	Very Good	Good	Fair	Poor	I do not remember
How to adjust medicines for your shortness of breath?	☐	☐	☐	☐	☐	☐
How to use inhaled medicines?	☐	☐	☐	☐	☐	☐
How to make asthma treatment fit in to your everyday life?	☐	☐	☐	☐	☐	☐

b. Do you use an inhaled steroid?

- ☐ Yes
- ☐ No
- ☐ Not sure

This brief "checkup" is designed to improve your health and health care. With your permission your name and year of birth are used to provide information and services suited to your needs.

16.Do you take medications more than three days a week for an illness or a medical problem?

- ☐ Yes
- ☐ No

17.In the last three months, did you have an illness or injury that kept you in bed for all or most of the day?

- ☐ Yes
- ☐ No

18. What is your weight in pounds (kilograms)?

What is your weight in pounds (kilograms)?
less than 100 (45)

100-120 (45-55)

121-140 (56-64)

141-160 (65-73)

161-180 (74-82)

181-200 (83-91)

201-220 (92-100)

221-240 (101-109)

241-260 (110-118)

261-280 (119-127)

281-300 (128-136)

301 or more (136)

☐

19. What is your height? (Choose closest value)
57 inches (145 cm, 4' 9")
59 inches (150 cm, 4' 11")
61 inches (155 cm, 5' 1")
63 inches (160 cm, 5' 3")
65 inches (165 cm, 5' 5")
67 inches (170 cm, 5' 7")
69 inches (175 cm, 5' 9")
71 inches (180 cm, 5' 11")
73 inches (185 cm, 6' 1")
75 inches (191 cm, 6' 3")
77 inches (196 cm, 6' 5")
79 inches (201 cm, 6' 7")

20. How many hours a day during the school week (Monday - Friday) do you watch television or play computer games?
Almost no TV or computer games

About one hour a day

About 2 hours a day

About 3 hours a day

About 4 hours a day

About 6 hours a day

About 8 hours a day

10 hours a day or more

☐

21. Which of the following best describes your family at HOME?

- ☐ One single natural (or biological) parent
- ☐ Two natural (or biological) parents
- ☐ One natural (or biological) parent and one step parent
- ☐ Living with another relative
- ☐ Living with unrelated adult(s)

22. Do you use or need any special equipment? Please list here:

_____

_____

¿Cómo está tu salud? – Evaluación para adolescente inscrito

POR FAVOR MARCA CON 'X' O ESCRIBE TUS RESPUESTAS

Nombre del joven: _____
Fecha de hoy: _____
Fecha de nacimiento del joven:_____

1. Sexo: Masculino Femenino

2. Durante el mes pasado, ¿con qué frecuencia hablaste acerca de tus problemas, sentimientos u opiniones con alguien de tu familia?

- ☐ Todo el tiempo
- ☐ Casi todo el tiempo
- ☐ Algunas veces
- ☐ Pocas veces
- ☐ En ningún momento

a. Contestaste que nunca o rara vez has hablado acerca de tus problemas, sentimiento u opiniones con alguien de tu familia. ¿Has hablado con alguien acerca del problema familiar?
   - ☐ Sí
   - ☐ No

b. Contestaste que hablaste con alguien acerca del problema familiar. ¿Te ayudó lo que se te dijo?
   - ☐ Extremadamente
   - ☐ Bastante
   - ☐ Moderadamente
   - ☐ Un poco
   - ☐ Para nada

c. Contestaste que hablaste con alguien acerca del problema familiar. ¿Quiénes fueron las personas con quien hablaste? (Por favor marca todo lo que aplique.)
   - ☐ Familia
   - ☐ Amistades
   - ☐ Doctores o enfermeros
   - ☐ Maestros o consejeros escolares
   - ☐ Otros

3Durante el mes pasado, ¿con qué frecuencia te sentiste ansioso(a), deprimido(a), irritable o triste?

- ☐ En ningún momento
- ☐ Pocas veces
- ☐ Algunas veces
- ☐ Casi todo el tiempo
- ☐ Todo el tiempo

a. Contestaste que te has sentido molesto(a) por tus sentimientos más de lo corriente. ¿Has hablado con alguien acerca de tus sentimientos?
   - ☐ Sí
   - ☐ No

b. Contestaste que has hablado con alguien acerca de tus sentimientos. ¿Te ayudó lo que se te dijo?
   - ☐ Extremadamente
   - ☐ Bastante
   - ☐ Moderadamente
   - ☐ Un poco
   - ☐ Para nada

c. Contestaste que has hablado con alguien acerca de tus sentimientos. ¿Quiénes fueron las personas con quien hablaste? (Por favor marca todo lo que aplique.)
   - ☐ Familia
   - ☐ Amistades
   - ☐ Doctores o enfermeros
   - ☐ Maestros o consejeros escolares
   - ☐ Otros

4 Durante el mes pasado, ¿con qué frecuencia hiciste cosas dañinas para tu salud, tales como fumar cigarillos o mascar tabaco, tener relaciones sexuales sin protección, o consumir alcohol incluyendo cerveza y vino?

- ☐ En ningún momento
- ☐ Pocas veces
- ☐ Algunas veces
- ☐ Casi todo el tiempo
- ☐ Todo el tiempo

a. Contestaste que frecuentemente haces cosas dañinas para tu salud. ¿Has hablado con alguien acerca de estas cosas?
   - ☐ Sí
   - ☐ No

Este breve "chequeo" está diseñado para mejorar su salud y servicios de salud. Con su permiso su nombre y año de nacimiento se usan para proveer información y servicios adecuados para sus necesidades.

b. Contestaste que hablaste con alguien acerca de tus hábitos dañinos para la salud. ¿Te ayudó lo que se te dijo?
   - ☐ Extremadamente
   - ☐ Bastante
   - ☐ Moderadamente
   - ☐ Un poco
   - ☐ Para nada

c. Contestaste que hablaste con alguien acerca de tus hábitos dañinos para la salud. ¿Quiénes fueron las personas con quien hablaste? (Por favor marca todo lo que aplique.)
   - ☐ Familia
   - ☐ Amistades
   - ☐ Doctores o enfermeros
   - ☐ Maestros o consejeros escolares
   - ☐ Otros

5 Durante el mes pasado, ¿con qué frecuencia te sentiste molesto(a) por dolores tales como dolor de espalda, dolor de cabeza, calambres o dolor de estómago?
- ☐ En ningún momento
- ☐ Pocas veces
- ☐ Algunas veces
- ☐ Casi todo el tiempo
- ☐ Todo el tiempo

a. Contestaste que te sientes molesto(a) por dolor corporal. ¿Has hablado con alguien acerca de tu dolor?
   - ☐ Sí
   - ☐ No

b. Contestaste que hablaste con alguien acerca de tu dolor corporal. ¿Te ayudó lo que se te dijo?
   - ☐ Extremadamente
   - ☐ Bastante
   - ☐ Moderadamente
   - ☐ Un poco
   - ☐ Para nada

c. Contestaste que te has sentido molesto(a) por dolor corporal. ¿Quiénes fueron las personas con quien hablaste? (Por favor marca todo lo que aplique.)
   - ☐ Familia
   - ☐ Amistades
   - ☐ Doctores o enfermeros
   - ☐ Maestros o consejeros escolares
   - ☐ Otros

6Durante el mes pasado, si necesitaste a alguien quien te escuchara o ayudara, ¿hubo alguien disponible?
- ☐ Sí, tanto como lo quise
- ☐ Sí, bastante
- ☐ Sí, algo
- ☐ Sí, un poco
- ☐ No, para nada

a. Contestaste que tuviste muy poco o ningún apoyo. ¿Has hablado con alguien acerca de este problema?
   - ☐ Sí
   - ☐ No

b. Contestaste que hablaste con alguien acerca de tu apoyo social. ¿Te ayudó lo que se te dijo?
   - ☐ Extremadamente
   - ☐ Bastante
   - ☐ Moderadamente
   - ☐ Un poco
   - ☐ Para nada

c. Contestaste que tuviste muy poco o ningún tipo de apoyo social. ¿Quiénes fueron las personas con quien hablaste? (Por favor marca todo lo que aplique.)
   - ☐ Familia
   - ☐ Amistades
   - ☐ Doctores o enfermeros
   - ☐ Maestros o consejeros escolares
   - ☐ Otros

7 Durante el mes pasado, ¿cuál fue la actividad física más difícil que pudiste hacer durante 10 minutos, por lo menos?
- ☐ Muy intensa
- ☐ Intensa
- ☐ Moderada
- ☐ Suave
- ☐ Muy suave

a. Contestaste que tienes dificultad en hacer actividades físicas. ¿Has hablado con alguien acerca de tu aptitud física?
   - ☐ Sí
   - ☐ No

b. Contestaste que hablaste con alguien acerca de tu aptitud física. ¿Te ayudó lo que se te dijo?
   - ☐ Extremadamente
   - ☐ Bastante
   - ☐ Moderadamente
   - ☐ Un poco
   - ☐ Para nada

c. Contestaste que hablaste con alguien acerca de tu aptitud física. ¿Quiénes fueron las personas con quien hablaste? (Por favor marca todo lo que aplique.)
   - ☐ Familia
   - ☐ Amistades
   - ☐ Doctores o enfermeros
   - ☐ Maestros o consejeros escolares
   - ☐ Otros

8 Durante el último mes que estuviste en el colegio, ¿cómo te fue?
- ☐ Hice muy bien
- ☐ Hice lo mejor que pude
- ☐ Pude haber hecho un poco mejor
- ☐ Pude haber hecho much mejor
- ☐ Hice mal

a. Contestaste que pudiste haber hecho mejor en el colegio. ¿Has hablado con alguien acerca de tu trabajo escolar?
   - ☐ Sí
   - ☐ No

b. Contestaste que has hablado con alguien acerca de tu trabajo escolar. ¿Te ayudó lo que se te dijo?
   - ☐ Extremadamente
   - ☐ Bastante
   - ☐ Moderadamente
   - ☐ Un poco
   - ☐ Para nada

c. Contestaste que has hablado con alguien acerca de tu trabajo escolar. ¿Quiénes fueron las personas con quien hablaste? (Por favor marca todo lo que aplique.)
   - ☐ Familia
   - ☐ Amistades
   - ☐ Doctores o enfermeros
   - ☐ Maestros o consejeros escolares
   - ☐ Otros

9 ¿Con qué frecuencia practicas buenos hábitos de la salud, en dos o más de las siguientes maneras?: ¿Usar cinturón de seguridad? ¿Hacer ejercicio? ¿Comer saludable? ¿Dormir suficiente? ¿Usar cascos de protección?
- ☐ Todo el tiempo
- ☐ Casi todo el tiempo
- ☐ Algunas veces
- ☐ Pocas veces
- ☐ En ningún momento

10 Las siguientes inyecciones (inmunizaciones) ayudan mucho a prevenir enfermedades malas. ¿Las has tenido?

	Sí	No	No estoy seguro(a)
Sarampión/Paperas/Rubéola (MMR, vacuna triple vírica)	☐	☐	☐
Tétano en los últimos 10 años	☐	☐	☐
Inyección contra la hepatitis B	☐	☐	☐
La varicela (varicella)	☐	☐	☐
Virus papiloma humano (VPH)	☐	☐	☐

☐

11Durante las CUATRO SEMANAS PASADAS, ¿con qué frecuencia te has molestado por cualquiera de los siguientes problemas?

	Nunca	Raramente	A veces	Frecuente	Siempre
Dolor de cabeza	☐	☐	☐	☐	☐
Dolores de estómago	☐	☐	☐	☐	☐
Mareos, cansancio, agotamiento	☐	☐	☐	☐	☐
Dolor de pecho	☐	☐	☐	☐	☐
Problemas menstruales	☐	☐	☐	☐	☐
Problemas de alimentación o de peso	☐	☐	☐	☐	☐

12Durante las CUATRO SEMANAS PASADAS, ¿con qué frecuencia te has molestado por cualquiera de los siguientes problemas?

	Nunca	Raramente	A veces	Frecuente	Siempre
Problemas de la piel	☐	☐	☐	☐	☐
Problemas sexuales	☐	☐	☐	☐	☐
Asma o problemas respiratorios	☐	☐	☐	☐	☐
Dificultad con prestar atención	☐	☐	☐	☐	☐
Dificultad con resolver problemas	☐	☐	☐	☐	☐

13¿Tienes alguna inquietud acerca de lo siguiente?:
(Por favor marca todo lo que aplique.)

- ☐ Violencia o abuso
- ☐ Temas sexuales o la contracepción
- ☐ SIDA y otras enfermedades de transmisión sexual
- ☐ Depresión y suicidio
- ☐ Abuso de sustancias (cerveza, vino, drogas)
- ☐ Ejercicios
- ☐ Nutrición, trastornos alimenticios
- ☐ Acceso a alimentos
- ☐ Acceso a vivienda estable y saludable
- ☐ Pérdida de servicio de calefacción, electricidad, agua o teléfono en mi hogar
- ☐ Dificultades yendo al o desde el colegio
- ☐ Oportunidades para trabajo de verano
- ☐ Clases para estudiantes de inglés como seguna lengua

14En el año pasado, ¿has visto a?:
(Por favor marca todo lo que aplique.)

- ☐ Un dentista
- ☐ Un doctor para los ojos
- ☐ Un consejero o psicólogo
- ☐ Otro doctor

15¿Tienes algún o algunos de los siguientes? (Marca todo lo que aplique.)

- ☐ Asma
- ☐ Otra enfermedad
- ☐ Obesidad (más de 15% sobrepeso)

a. Si indicaste que tienes asma o un problema respiratorio, ¿cómo clasificarías la información que tu doctor o enfermero te dio sobre:

	Excelente	Muy buena	Buena	Justa	Mala	No recuerdo
¿Cómo ajustar medicamentos para falta de aire?	☐	☐	☐	☐	☐	☐
¿Cómo usar medicamentos que se inhalan?	☐	☐	☐	☐	☐	☐

b. ¿Usas esteroide que se inhala?
- ☐ Sí
- ☐ No
- ☐ No estoy seguro(a)

16 ¿Tomas medicamentos por más de tres días a la semana para una enfermedad o problema médico?
- ☐ Sí
- ☐ No

17En los últimos tres meses, ¿tuviste una enfermedad o lesión que te mantuvo en cama por todo o casi todo el día?
- ☐ Sí
- ☐ No

18¿Cuánto pesas en libras (kilogramos)?
¿Cuánto pesas en libras (kilogramos)?
Menos de 100 (45)

100-120 (45-55)

121-140 (56-64)

141-160 (65-73)

161-180 (74-82)

181-200 (83-91)

201-220 (92-100)

221-240 (101-109)

241-260 (110-118)

261-280 (119-127)

281-300 (128-136)

301 o más (136)

☐

19 ¿Cuánto mides de estatura? (Elije el valor que más se aproxima)
57 pulgadas (145 cm, 4' 9")
59 pulgadas (150 cm, 4' 11")
61 pulgadas (155 cm, 5' 1")
63 pulgadas (160 cm, 5' 3")
65 pulgadas (165 cm, 5' 5")
67 pulgadas (170 cm, 5' 7")
69 pulgadas (175 cm, 5' 9")
71 pulgadas (180 cm, 5' 11")
73 pulgadas (185 cm, 6' 1")
75 pulgadas (191 cm, 6' 3")
77 pulgadas (196 cm, 6' 5")
79 pulgadas (201 cm, 6' 7")

20 Durante la semana escolar (lunes a viernes), ¿cuántas horas al día ves televisión o juegas juegos de computadora?

Casi no veo televisión ni juego juegos de computadora

Como una hora al día

Como 2 horas al día

Como 3 horas al día

Como 4 horas al día

Como 6 horas al día

Como 8 horas al día

10 horas al día o más

☐

21¿Cuál de los siguientes mejor describe tu familia en tu HOGAR?
- ☐ Padre/Madre único/a natural (o biológico/a)
- ☐ Dos padres naturales (o biológicos)
- ☐ Un/a padre/madre natural (o biológico/a) y un/a padrastro/madrastra
- ☐ Vivo con otro pariente
- ☐ Vivo con adulto(s) no relacionado(s)

22 ¿Usas o necesitas algún equipo o aparato especial? Por favor lista aquí:

_____

_____

COMMUNITY CARE COOPERATIVE

How's Your Health - Child Enrollee Screen

PLEASE "X" OR WRITE YOUR ANSWERS

Child's Name: _____

Today's Date: _____

Child's Date of Birth: _____

About Your Child

1. Your preferred language is?

   English Espanol Other Language (**Write Below**)

   _____

2. Are you a male or female?
   - ☐ Male
   - Female

3. How fast can your child run in a race?
   - ☐ Very fast
   - ☐ Fast
   - ☐ Slowly
   - ☐ Very slowly
   - ☐ Not run at all

   a. You answered that your child has difficulty doing physical activities. Have you talked to anyone about your child's physical fitness?
      - ☐ Yes
      - ☐ No

   b. You answered that you have talked to someone about your child's physical fitness. Was what you were told helpful for you?
      - ☐ Extremely
      - ☐ Quite a lot
      - ☐ Moderately
      - ☐ A little
      - ☐ Not at all

   c. You answered that you talked to someone about your child's physical fitness. Who were the people you spoke to? (Please mark all that apply.)
      - ☐ Family
      - ☐ Friends
      - ☐ Doctors or nurses
      - ☐ Teachers or school counselors
      - ☐ Others

4. During the past month, how often did your child seem sad, unhappy, worried, or upset?
   - ☐ None of the time
   - ☐ A little of the time
   - ☐ Some of the time
   - ☐ Most of the time
   - ☐ All of the time

   a. You answered that your child has been bothered by his/her feelings. Have you talked to anyone about your child's feelings?
      - ☐ Yes
      - ☐ No

   b. You answered that you have talked to someone about your child's feelings. Was what you were told helpful to you?
      - ☐ Extremely
      - ☐ Quite a lot
      - ☐ Moderately
      - ☐ A little
      - ☐ Not at all

   c. You answered that you have talked to someone about your child's feelings. Who were the people you spoke to? (Please mark all that apply.)
      - ☐ Family
      - ☐ Friends
      - ☐ Doctors or nurses
      - ☐ Teachers or school counselors
      - ☐ Others

5. How many hours a day during the week does your child watch television or play computer games?
   - ☐ Less than 1 hour
   - ☐ 1-3 hours
   - ☐ More than 3 hours

6. How often does your child practice good health habits, such as: Wearing seat and shoulder belt? Wearing safety helmets? Not playing with matches or fire? Getting exercise? Eating right? Brushing teeth? Being careful around strangers and traffic?
   - ☐ All of the time
   - ☐ Most of the time
   - ☐ Some of the time
   - ☐ A little of the time
   - ☐ None of the time

7. Does your child take medications for an illness or a medical problem?

This brief "checkup" is designed to improve your health and health care. With your permission your name and year of birth are used to provide information and services suited to your needs.

- ☐ Yes
- ☐ No

8. In the past month, did your child have an illness or injury that kept him or her in bed for all or most of the day?
- ☐ Yes
- ☐ No

9. During the past 4 weeks, has your child's physical and emotional health limited his/her social activities with family friends, neighbors or groups?
- ☐ Not at all
- ☐ Slightly
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely

10. **If your child is age 5-8,** during the past month, how well did your child do in preschool or school?
- ☐ Very well
- ☐ As well as she/he could
- ☐ Could have done better
- ☐ Could have done much better
- ☐ Very poor
- ☐ Not in school

11. **If your child is age 2-4,** how is your child speaking compared to other children the same age?
- ☐ Very well
- ☐ Ok
- ☐ Not very well
- ☐ I am not sure

About Your Child's Health Care and Support

13. Does your child have a single health care doctor or nurse or health care practice site that you consider the medical home for your child?
- ☐ Yes
- ☐ No
- ☐ Not Sure

14. Do your child's doctors or nurses spend enough time with you and your child at your child's visits?
- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Seldom
- ☐ Never

15. Do your child's doctors or nurses answer your concerns about your child?
- ☐ Always
- ☐ Usually
- ☐ Sometimes
- ☐ Seldom
- ☐ Never

16. Are there things about your child's medical care that could be better?
- ☐ No, the care is perfect
- ☐ Yes, some things
- ☐ Yes a lot of things

How easy is it to get medical care for your child when you need it?
- ☐ Very easy
- ☐ Easy
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ My child has not needed medical care

17. Has your child had?

	Yes	No	Not sure
2nd MMR (Measles/Mumps/Rubella) Shot?	☐	☐	☐
Tetanus Booster near the time he/she started school?	☐	☐	☐
Either Chicken Pox or the Chicken Pox Vaccine	☐	☐	☐
Human Papilloma Virus (HPV) Vaccine	☐	☐	☐

18. Do you have a written copy of the immunizations (shots) your child has had?
- ☐ Yes
- ☐ No

This brief "checkup" is designed to improve your health and health care. With your permission your name and year of birth are used to provide information and services suited to your needs.

☐ I am not sure

19. Does your child have any of the following? Mark all that apply.

	Yes	No	Not sure
Asthma	☐	☐	☐
Another disease	☐	☐	☐
Obesity (more than 15% overweight)	☐	☐	☐

a. If you indicated that your child has asthma or a breathing problem, how would you rate the information your doctor or a nurse gave you about:

	Excellent	Very Good	Good	Fair	Poor	I do not remember
How to adjust medicines for your child's shortness of breath?	☐	☐	☐	☐	☐	☐
How to use inhaled medicines?	☐	☐	☐	☐	☐	☐

b. Does your child use an inhaled steroid?
- ☐ Yes
- ☐ No
- ☐ Not Sure

20. In the past year, has your child seen:
- ☐ A dentist
- ☐ An eye doctor
- ☐ A counselor/psychologist
- ☐ Another doctor

About Your Child's Home and Environment

21. During the past month, if you needed someone to listen or help about your child, was someone there for you?
- ☐ Yes, as much as I wanted
- ☐ Yes, quite a bit
- ☐ Yes, some
- ☐ Yes, a little
- ☐ No, not at all

a. You answered "yes, a little or no" social support. Have you talked to anyone about this problem?
- ☐ Yes
- ☐ No

b. You answered that you talked to someone about your child. Was what you were told helpful for you?
- ☐ Extremely
- ☐ Quite a lot
- ☐ Moderately
- ☐ A little
- ☐ Not at all

c. Who were the people you spoke to? (Please mark all that apply.)
- ☐ Family
- ☐ Friends
- ☐ Doctors or nurses
- ☐ Teachers or school counselors
- ☐ Others

22. Are you the child's:
- ☐ Mother
- ☐ Stepmother
- ☐ Father
- ☐ Stepfather
- ☐ Other

23. How much have you done to protect your child, such as: Have the Poison Control phone number? Store drugs, cleaners, guns, matches out of reach? Set hot water heater to a temperature less than 130 degrees? Prevent from drowning? Have a working smoke detector?
- ☐ Every safe thing that I know
- ☐ Almost every safe thing
- ☐ Some safe things
- ☐ A few safe things
- ☐ Not many safe things

24.How much have you done to keep your child safe outside of the home such as: Using seat belts? Making sure the car is inspected and safe? Not leaving your child alone in public places? Not allowing the child to be with careless or dangerous persons?
- ☐ Every safe thing that I know
- ☐ Almost every safe thing
- ☐ Some safe things
- ☐ A few safe things
- ☐ Not many safe things

25. Your health habits impact your child. How are you doing with such health habits as: Your use of cigarette and tobacco products? Your temper? Your eating and exercise habits? Your use of regular medical care for yourself? Your use of alcohol?

- ☐ Perfectly
- ☐ Very well
- ☐ Pretty good
- ☐ Only fair
- ☐ Poor

26. During the past 4 weeks, how often have problems in your household led to: Insulting or swearing? Threatening? Yelling? Hitting or pushing?

- ☐ None of the time
- ☐ A little of the time
- ☐ Some of the time
- ☐ Most of the time

27. Do you have enough money to buy the essential things you need such as food, clothing, or housing?

- ☐ Yes, always
- ☐ Yes, sometimes
- ☐ No

28. Do you have concerns about any of the following? (Please mark all that apply.)

- ☐ How to keep my child safe
- ☐ What is normal for my child
- ☐ Health, eating, and habits
- ☐ How to manage pain
- ☐ How to manage behavior problems
- ☐ How to help learning
- ☐ How to manage school or day care problems
- ☐ Transportation to or from school or day care
- ☐ When money is hard to find, how can I help my child

29. Does your child use or need any special equipment? Please list here:

_____

_____

Thank you very much for completing your Checkup.

12. How often is your child bothered by problems with:

	Never	Seldom	Sometimes	Often	Always
Behavior and temper	☐	☐	☐	☐	☐
Asthma or Breathing problems	☐	☐	☐	☐	☐
Chest pains	☐	☐	☐	☐	☐
Colds, sore throats, or fevers	☐	☐	☐	☐	☐
Ear infections	☐	☐	☐	☐	☐
Eating or weight problems	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Skin problems	☐	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	☐
Stomach pains	☐	☐	☐	☐	☐
Tired and low energy	☐	☐	☐	☐	☐
Trouble hearing	☐	☐	☐	☐	☐
Trouble paying attention	☐	☐	☐	☐	☐
Trouble seeing	☐	☐	☐	☐	☐

This brief "checkup" is designed to improve your health and health care. With your permission your name and year of birth are used to provide information and services suited to your needs.

¿Cómo está su salud? – Evaluación para menor inscrito

POR FAVOR MARQUE CON 'X' O ESCRIBA SUS RESPUESTAS

Acerca de su niño(a)

1. ¿Es usted hombre o mujer?
   - ☐ Hombre
   - Mujer

2. ¿Cuán rápido puede su niño(a) correr en una carrera?
   - ☐ Muy rápido
   - ☐ Rápido
   - ☐ Lentamente
   - ☐ Muy lentamente
   - ☐ No corre para nada

   a. Usted contestó que su niño(a) tiene dificultad haciendo actividades físicas. ¿Usted ha hablado con alguien acerca de la aptitud física de su niño(a)?
      - ☐ Sí
      - ☐ No

   b. Usted contestó que ha hablado con alguien acerca de la aptitude física de su niño(a). ¿Le ayudó lo que le dijeron?
      - ☐ Extremadamente
      - ☐ Bastante
      - ☐ Moderadamente
      - ☐ Un poco
      - ☐ Para nada

   c. Usted contestó que habló con alguien acerca de la aptitud física de su niño(a). ¿Quiénes fueron las personas con quien usted habló? (Por favor maque todo lo que aplique.)
      - ☐ Familia
      - ☐ Amistades
      - ☐ Doctores o enfermeras
      - ☐ Maestros o consejeros escolares
      - ☐ Otros

3. Durante el mes pasado, ¿con qué frecuencia su niño(a) le pareció triste, descontento(a), preocupado(a) o molesto(a)?
   - ☐ En ningún momento
   - ☐ Pocas veces
   - ☐ Algunas veces
   - ☐ Casi todo el tiempo
   - ☐ Todo el tiempo

   a. Usted contestó que su niño(a) se ha sentido molesto(a) por sus propios sentimientos. ¿Usted ha hablado con alguien acerca de los sentimientos de su niño(a)?
      - ☐ Sí
      - ☐ No

   b. Usted contestó que ha hablado con alguien acerca de los sentimientos de su niño(a). ¿Le ayudó lo que le dijeron?
      - ☐ Extremadamente
      - ☐ Bastante
      - ☐ Moderadamente
      - ☐ Un poco
      - ☐ Para nada

   c. Usted contestó que usted ha hablado con alguien acerca de los sentimientos de su niño(a). ¿Quiénes fueron las personas con quien usted habló? (Por favor marque todo lo que aplique.)
      - ☐ Familia
      - ☐ Amistades
      - ☐ Doctores o enfermeras
      - ☐ Maestros o consejeros escolares
      - ☐ Otros

4. ¿Cuántas horas al día su niño(a) ve televisión o juega juegos de computadora?
   - ☐ Menos de 1 hora
   - ☐ 1-3 horas
   - ☐ Más de 3 horas

5. ¿Con qué frecuencia su niño(a) practica buenos hábitos de la salud? Tales como: ¿Usar cinturón de seguridad para cadera y hombros? ¿Usar cascos de protección? ¿No jugar con fósforos o fuego? ¿Hacer ejercicio? ¿Comer saludable? ¿Cepillarse los dientes? ¿Tener cuidado con extraños y el tráfico?
   - ☐ Todo el tiempo
   - ☐ Casi todo el tiempo
   - ☐ Algunas veces
   - ☐ Pocas veces
   - ☐ En ningún momento

6. ¿Su niño(a) toma medicamento(s) para una enfermedad o un problema médico?
   - ☐ Sí
   - ☐ No

Este breve "chequeo" está diseñado para mejorar su salud y servicios de salud. Con su permiso su nombre y año de nacimiento se usan para proveer información y servicios adecuados para sus necesidades.

THIS SHOULD BE AT TOP OF PAGE TO BE SIMILAR TO OTHERS

Nombre del niño(a): _____

Fecha de hoy: _____

Fecha de nacimiento del niño(a):_____

7. En el mes pasado, ¿su niño(a) tuvo una enfermedad o lesión que lo/la mantuvo en cama por todo o casi todo el día?

- ☐ Sí
- ☐ No

8. Durante las últimas 4 semanas, ¿su niño(a) ha limitado actividades sociales con la familia, amistades, vecinos, o grupos debido a la salud física y emocional de él/ella?

- ☐ Para nada
- ☐ Algo
- ☐ Moderadamente
- ☐ Bastante
- ☐ Extremadamente

9. Si su niño(a) tiene la edad entre 5-8 años, durante el mes pasado, ¿qué tan bien le fue a su niño(a) en preescolar o en el colegio?

- ☐ Muy bien
- ☐ Lo mejor que ella/él pudo
- ☐ Pudo haber hecho mejor
- ☐ Pudo haber hecho mucho mejor
- ☐ Muy mal
- ☐ No está en el colegio

10. Si su niño(a) tiene la edad entre 2-4 años, ¿cómo está hablando su niño(a) comparado(a) con otros niños de la misma edad?

- ☐ Muy bien
- ☐ Bien
- ☐ No muy bien
- ☐ No estoy seguro(a)

11. ¿Con qué frecuencia su niño(a) se molesta por los siguientes problemas?:

	Nada	Un poco	Algo	Frecuente	Siempre
Comportamiento y temperamento	☐	☐	☐	☐	☐
Asma o problemas respiratorios	☐	☐	☐	☐	☐
Dolores de pecho	☐	☐	☐	☐	☐
Resfriados, dolor de garganta, o fiebre	☐	☐	☐	☐	☐
Infecciónes de oído	☐	☐	☐	☐	☐
Comer o problemas de peso	☐	☐	☐	☐	☐
Dolores de cabeza	☐	☐	☐	☐	☐
Problemas de la piel	☐	☐	☐	☐	☐
Dormir	☐	☐	☐	☐	☐
Dolores de estómago	☐	☐	☐	☐	☐
Cansado(a) y falta de energía	☐	☐	☐	☐	☐
Dificultad con audición	☐	☐	☐	☐	☐
Dificultad con prestar atención	☐	☐	☐	☐	☐
Dificultad de la vista	☐	☐	☐	☐	☐

Acerca del apoyo y servicio de salud de su niño(a)

12. ¿Tiene su niño(a) un solo doctor o enfermero, o un centro de servicio de salud médico que usted considera como el hogar médico para su niño(a) ?

- ☐ Sí
- ☐ No

13. ¿Los doctores o enfermeros de su niño(a) pasan suficiente tiempo con usted y su niño(a) durante las citas con su niño(a)?

- ☐ Siempre
- ☐ Usualmente
- ☐ A veces
- ☐ Raramente
- ☐ Nunca

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14. ¿Los doctores o enfermeros de su niño(a) responden a sus inquietudes sobre su niño(a)?

- ☐ Siempre
- ☐ Usualmente
- ☐ A veces
- ☐ Raramente
- ☐ Nunca

15. ¿Hay cosas acerca del cuidado médico de su niño(a) que podría ser mejor?

- ☐ No, el cuidado médico está perfecto
- ☐ Sí, algunas cosas
- ☐ Sí, muchas cosas

16 ¿Qué tan fácil es conseguir cuidado médico para su niño(a) cuando lo necesita?

- ☐ Muy fácil
- ☐ Fácil
- ☐ Algo difícil
- ☐ Muy difícil
- ☐ Mi niñ0(a) no ha necesitado cuidado médico

17. ¿Su niño(a) ha tenido?:

	Sí	No	No estoy seguro(a)
¿La 2da vacuna de MMR (vacuna triple vírica, Sarampión/Paperas/Rubéola)?	☐	☐	☐
¿Refuerzo antitetánico cerca del tiempo que él/ella comenzó el colegio?	☐	☐	☐
¿La varicela o vacuna contra la varicela?	☐	☐	☐
¿Vacuna contra el VPH (virus papiloma humano)?	☐	☐	☐

18. ¿Tiene usted un registro de inmunización (inyecciones) que su niño(a) ha tenido?

- ☐ Sí
- ☐ No

☐ No estoy seguro(a)

19. ¿Su niño(a) tiene algún o algunos de los siguientes? Marque todo lo que aplique.

	Sí	No	No estoy seguro(a)
Asma	☐	☐	☐
Otra enfermedad	☐	☐	☐
Obesidad (más de 15% sobrepeso)	☐	☐	☐

a. Si usted indicó que su niño(a) tiene asma o un problema respiratorio, ¿cómo clasificaría la información que su doctor o enfermero le dio sobre:

	Excelente	Muy buena	Buena	Justa	Mala	No recuerdo
¿Cómo ajustar medicamentos para tratar falta de aire en su niño(a)?	☐	☐	☐	☐	☐	☐
¿Cómo usar medicamentos inhalados?	☐	☐	☐	☐	☐	☐

b. ¿Su niño(a) usa un esteroide inhalado?

- ☐ Sí
- ☐ No
- ☐ No estoy seguro(a)

20. En el último año, ¿su niño(a) ha visto a?:

- ☐ Un dentista
- ☐ Un doctor para los ojos
- ☐ Un consejero/psicólogo
- ☐ Otro doctor

Acerca del hogar y entorno de su niño(a)

21. Durante el mes pasado, si usted necesitó a alguien quien escuche o ayude con cuestiones acerca de su niño(a), ¿hubo alguien disponible?

- ☐ Sí, tanto como lo quise
- ☐ Sí, bastante
- ☐ Sí, algo
- ☐ Sí, un poco
- ☐ No, para nada

a. Usted contestó 'Sí, un poco' o 'No'. ¿Ha hablado con alguien acerca de este problema?
   - ☐ Sí
   - ☐ No

b. Usted contestó que habló con alguien acerca de su niño(a). ¿Le ayudó lo que le dijeron?
   - ☐ Extremadamente
   - ☐ Bastante
   - ☐ Moderadamente
   - ☐ Un poco
   - ☐ Para nada

c. ¿Quiénes fueron las personas con quien usted habló? (Por favor marque todo lo que aplique.)
   - ☐ Familia
   - ☐ Amistades
   - ☐ Doctores o enfermeras
   - ☐ Maestros o consejeros escolar
   - ☐ Otros

22. Su relación al niño(a):

- ☐ Madre
- ☐ Madrastra
- ☐ Padre
- ☐ Padrastro
- ☐ Otra

23. ¿Cuánto ha hecho usted para proteger a su niño(a)? Como: ¿Tener el número teléfonico de Poison Control (Centro de Toxicología)? ¿Guardar droga, productos de limpieza, armas y fósforos fuera de alcance? ¿Ajustar el calentador de agua a una temperatura menos de 130 grados? ¿Prevenir ahogo? ¿Tener detector de humo que funcione?

- ☐ Todo lo que sé sobre la seguridad
- ☐ Casi todo sobre la seguridad
- ☐ Algunas cosas sobre la seguridad
- ☐ Unas pocas cosas sobre la seguridad
- ☐ No muchas cosas sobre la seguridad

24. ¿Cuánto ha hecho para mantener a su niño(a) seguro(a) fuera del hogar? Como: ¿Usar cinturón de seguridad? ¿Asegurarse que el carro sea inspeccionado y seguro? ¿No dejar a su niño(a) solo(a) en sitios públicos? ¿No permitir que su niño(a) esté con personas irresponsables o peligrosas?

- ☐ Todo lo que sé sobre la seguridad
- ☐ Casi todo sobre la seguridad
- ☐ Algunas cosas sobre la seguridad
- ☐ Unas pocas cosas sobre la seguridad
- ☐ No muchas cosas sobre la seguridad

25. Sus hábitos de la salud impacta a su niño(a). ¿Cómo le va con hábitos de la salud? Tales como: ¿Su uso de productos de tabaco y cigarrillos? ¿Su temperamento? ¿Sus hábitos de comer y ejercicio? ¿Su uso de atención médica habitual para sí mismo? ¿Su uso de alcohol?

- ☐ Perfectamente
- ☐ Muy bien
- ☐ Bastante bien
- ☐ Solo justo
- ☐ Mal

26. Durante las 4 semanas pasadas, ¿con qué frecuencia ha tenido problemas en su familia que resultaron en: ¿Insultar o maldecir? ¿Amenazar? ¿Gritar? ¿Golpear o empujar?

- ☐ En ningún momento
- ☐ Pocas veces
- ☐ Todo el tiempo
- ☐ Algunas veces
- ☐ Casi todo el tiempo

27. ¿Tiene usted suficiente dinero para comprar las cosas indispensables que necesita tales como alimentos, ropa o vivienda?

- ☐ Sí, siempre
- ☐ Sí, a veces
- ☐ No

28. ¿Tiene alguna inquietud sobre cualesquiera de los siguientes? (Por favor marque todo lo que aplique.)

- ☐ Cómo mantener a mi niño(a) seguro(a)
- ☐ Qué es normal para mi niño(a)
- ☐ Salud, alimentación, y hábitos
- ☐ Cómo controlar el dolor
- ☐ Cómo controlar problemas del comportamiento
- ☐ Cómo ayudar con el aprendizaje

- ☐ Cómo manejar problemas del colegio o guardería
- ☐ Transporte hacia o desde el colegio o guardería
- ☐ Cómo ayudar a mi niño(a) cuando el dinero no alcanza

29. ¿Su niño(a) usa o necesita algún equipo especial? Por favor liste aquí:

_____

_____

Muchas gracias por completar su Chequeo.