United American Indian Involvement, Inc.

1125 West Sixth Street, Suite 103 Los Angeles, CA 90017 (213)202-3970 Fax (213)202-3977

INFORMED CONSENT AND DISCLOSURE OF SERVICES

I understand that the services provided by the United American Indian Involvement, Inc. (UAII) include direct services as well as referral and linkage services.

UAII PROVIDES THE FOLLOWING SERVICES AS APPROPRIATE TO EACH CLIENT:

- Substance Use/Abuse Services
- Case Management Services
- Employment Services
- Social Services (Housing, Nutrition, Transportation)
- Senior Activities
- Cultural/Spiritual Activities
- Medical Services
- Benefits Coordination
- Mental Health Services
- Referral to Medical Services
- Referral to Dental Services
- Referral to Residential Treatment/Detox
- Referral to Sober Living
- Referral to Traditional Practitioners

The direct services listed above are provided free of charge to all qualified UAII Clients. UAII staff will work with the clients to secure services and funding available from various resources outside of UAII. Neither UAII nor any UAII programs guarantee payment for services that are referred to an appropriate health or substance abuse treatment provider.

Initials _____ I understand that this consent acknowledges my participation in the services provided by UAII & requires the discussion of my health conditions and health needs with a UAII staff member.

Initials _____ I authorize UAII staff to provide the necessary or advisable health screening, assessments and evaluations for the purpose of providing direct services and linkage/referral services for:

☐ Myself _____(Print Name)

☐ My Child _____(Print Child's Name)

Initials _____ I understand that some or all of my/my child's personal health information may be shared among UAII Professional Staff and outside Service Providers in order to link me/my child to the appropriate services and to provide active case management services.

Initials _____ I understand that UAII and any UAII Programs are not responsible for fees to outside service providers unless I obtain a written referral/authorization for payment from my Case Manager prior to service.

Patient Release(s) of Information

I, _____hereby authorize UAII to request and receive copies of my/my child's medical/social services and/or employment information for any services that I receive from outside service providers. I understand that this information will be used to update my records and UAII and to provide appropriate Case Management follow-up and referral services. I further understand and agree that requests for specific information regarding HIV/AIDS status and/or treatment, treatment for drug, alcohol or substance abuse and information related to the treatment of mental health, developmental or psychiatric conditions require a separate consent.

Signed:_____ Date: _____

Release of Information/Assignment of Benefits

UAII has my permission to release information for myself/my child as needed for insurance processing and to release payment to UAII.

I HEREBY AUTHORIZE TREATMENT

Signed: _____ Date: _____

UAII Staff Witness: _____ Date: _____

United American Indian Involvement, Inc.

Los Angeles, California

CLIENT REGISTRATION INTAKE FORM

All Information provided is CONFIDENTIAL

UAII Staff Use Only
_____New _____Update

HR#_____

Important: *If client is under the age of 18 years, this form is to be filled out and signed by legal parent or guardian.*

Today's Date: _____

Client's Full Name: _____ Other Name(s) Used: _____

Sex: (Circle One) Male Female T/G Date of Birth: ____/____/____ Soc. Sec. # _____-____-_____

Place of Birth: (City and State) _____ Marital Status: _____(i.e. married, single)

Present Address: _____
Street City State Zip Code

Home Phone: (_____)_____-_____ Office: (_____)_____-_____ Other: (_____)_____-_____
Message or cell phone number?

Do you have internet access? (Circle one) Yes No If yes, where do you access the internet? _____

Email Address: _____@_____.com

When did you move to your current community? _____ (i.e. June 1st, 1975)

Living Arrangements: (Circle one) Living with Family Homeless In Treatment Other:_____

Preferred Method of Contact: (Circle one) Mail Phone E-mail

May we send you generic health messages through e-mail? (Circle one) Yes No

TRIBAL INFORMATION

Tribal Affiliation: _____ _____
(Reservation, Rancheria, Native Corp., Public Law Land)

Blood Quantum: _____ Enrollment # _____ Other Tribes: _____
(i.e. Full ¾ ½ ¼ ⅛)

PARENT INFORMATION

Mother / Guardian 1: _____
Last Name First Relationship to client

Telephone: (_____) _____-_____ (_____) _____-_____ _____@_____.com
Cell Phone Alt. Phone Email Address

Father / Guardian 2: _____
Last Name First Relationship to client

Telephone: (_____) _____-_____ (_____) _____-_____ _____@_____.com
Cell Phone Alt. Phone Email Address

EMERGENCY CONTACT

Name: _____
Last Name First Relationship to client

Address: _____
Street City State Zip Code

Telephone: _____
Home Phone # Work Phone # Mobile Phone #

NEXT OF KIN (NOT LIVING WITH YOU)

Name: _____
Last Name First Relationship to client

Address: _____
Street City State Zip Code

Telephone: _____
Home Phone # Work Phone # Mobile Phone #

Continue on back side

United American Indian Involvement, Inc.

Los Angeles, California

CLIENT REGISTRATION INTAKE FORM

All Information provided is CONFIDENTIAL

UAII Staff Use Only
_____New _____Update

HR#_____

Household:

Name	Relationship to client	Sex	AI/AN	DOB	Source of Income	Amount Received
1. Client	Self					
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10						
Total # in household _____					Total Household Monthly Income	

Employment Information:

Employer	**Address**	**Phone**	**Employment Status**
			Full Time ❑ Part Time ❑ Self Employed ❑ Retired ❑ Unemployed ❑
Employer (Spouse's info)	**Address**	**Phone**	**Employment Status**
			Full Time ❑ Part Time ❑ Self Employed ❑ Retired ❑ Unemployed ❑

Employer (If Minor, Father's info)	**Address**	**Phone**	**Employment Status**
			Full Time ❑ Part Time ❑ Self Employed ❑ Retired ❑ Unemployed ❑
Employer (If Minor, Mother's info)	**Address**	**Phone**	**Employment Status**
			Full Time ❑ Part Time ❑ Self Employed ❑ Retired ❑ Unemployed ❑

Continue on next page

United American Indian Involvement, Inc.

Los Angeles, California

CLIENT REGISTRATION INTAKE FORM

All Information provided is CONFIDENTIAL

UAII Staff Use Only
_____New _____Update

HR#_____

Health Insurance Information: Do you have medical health insurance? **Yes** **No**

If **yes**, please indicate type: (Check one or more boxes that apply and provide further insurance information as requested below)

☐ **Medicare** (Circle one) ☐ **Medi-Cal**: _____ ☐ **Family Pact** ☐ **HMO**: _____

Part A (i.e. Health Net, Kaiser, Molina, etc) (i.e. Blue Cross, Blue Shield, Cigna, etc.)

Part B Is your Medi-Cal Insurer: (circle one)

Part D a. Straight Medi-Cal or

Railroad b. Under a Managed Care Plan

☐ **Kaiser Permanente** ☐ **Private**: _____ ☐ **PPO**:_____ ☐ **Veteran**

(i.e. Blue Cross, Blue Shield, Cigna, etc.) (i.e. Blue Cross, Blue Shield, Cigna, etc.)

Health Insurance ID #: _____ Eligibility Date or Insurance Issue Date: _____/_____/_____

Primary Care Provider: _____ (i.e. Dr. Jane Doe, M.D.) PCP Phone #: ( ) _____-_____

Are you a veteran? (Circle One) Yes No (If yes, Patient Reg. Staff will ask you additional questions)

Primary Language Spoken: _____ Other Languages Spoken: _____

Do you identify yourself as Hispanic or Latino? (Circle one) Yes No Unknown Decline to Answer

Race: (if other than Amer. Indian) _____

My Signature is a statement that the information provided on this form is true and correct

_____ ____/____/____ _____ ____/____/____

Client Signature or Parent / Legal Guardian Date UAII Staff Initials Date

United American Indian Involvement, Inc.

Client's Bill of Rights and Responsibilities

The client has the right to receive services and to exercise the following rights without regard to gender, culture, ethnic group identification, economic status, education level, disability, age, creed, religion or sexual orientation. This statement shall not preclude United American Indian Involvement, Inc. (UAII) from emphasizing services for the American Indian/Alaska Native (AI/AN) community:

❖ The client has the right to receive considerate and respectful care and to be accorded dignity in contact with staff, volunteers, board members, and other persons.

❖ The client has the right to be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior.

❖ The client has the right to expect that all communications and records pertaining to his/her care be treated as **confidential** except in cases of threat to self or others, child abuse, elder or dependent adult abuse or court order. The client's written permission shall be obtained before their records can be made available to anyone not directly concerned with their care. UAII shall assure confidentiality in accordance with Title 42, Code of Federal Regulations, Part 2.

❖ The client has the right to know the name of the provider who has primary responsibility for coordinating their care and the names and professional relationships of other providers who will see them.

❖ The client has the right to obtain complete and current information concerning their diagnosis, treatment, and prognosis in terms that the client can be reasonably expected to understand.

❖ The client has the right to participate in decisions regarding their care unless the health or safety of self or others is being compromised or the client is in an altered state.

❖ The client has the right to refuse treatment to the extent permitted by law, and to be informed of the health care consequences of the action.

❖ The client has the right to be accorded access to his or her file.

❖ The client has the right to leave the premises even against the advice of their providers.

❖ The client has the right to expect that UAII will make reasonable response to all requests for services and provide clear explanations for any services that cannot be provided.

❖ The client has the right to expect reasonable continuity of care and to know in advance the time and location of appointments.

❖ The client has the right to know what the program rules and regulations are that apply to his/her participation in the program.

❖ The client has the right to be advised if the provider proposes to engage in research or perform experimentation that in any way affects their care. The Client has the Right to Refuse participation in Experimental Research.

❖ The client has the right to be accorded safe, healthful and comfortable accommodations to meet his or her needs.

❖ The client's rights will be extended to and apply to any person who is identified to have legal responsibility to make decisions regarding the care of the client.

❖ The client has the right to appeal a discharge or file a complaint with the Program Director according to the grievance procedure*.

CLIENTS HAVE THE RESPONSIBILITY TO:

❖ Provide accurate and complete information concerning your health history, financial status and/or any other information that is required by UAII in order to provide services.

❖ Inform UAII and/or referring facilities if you are not able to keep any appointments 24 hours prior to the scheduled appointment.

❖ Request further information concerning anything you do not understand.

❖ Speak with the Program Director if you are having difficulty with any staff member.

❖ Treat the staff and other clients in a respectful and courteous manner.

❖ Follow all rules and guidelines for program participation and use of the UAII facilities.

UAII HAS THE RIGHT TO:

❖ Refuse service to any client who is verbally or physically abusive or threatening to any staff member or other client (on the phone or in person).

❖ Refuse service to any client who is under the influence of alcohol, drugs or other substance.

❖ Suspend or terminate services of any client who does not comply with the guidelines or rules that are outlined for use of UAII programs or facilities.

I have reviewed the Client's Bill of Rights and Responsibilities and understand what my rights and responsibilities are as described above. Furthermore, I understand that I may file a grievance using UAII procedures* if I feel these rights have been violated.

Print name of Client _____

Signature of Client _____ Date _____

Signature of UAII Staff _____ Date_____

<u>* The Grievance Policy and Consumer Complaint/Grievance Forms are available at the front desk upon request.</u>

United American Indian Involvement

Acknowledgment declaring awareness of 2013 Notice of Privacy Practices

I hereby acknowledge that I am aware that UAII has a Notice of Privacy Practices (NPP) which details or summarizes my rights involving my protected health information (PHI). This notice is available to me in both printed and electronic formats. UAII has this notice clearly posted on the walls in all UAII waiting areas; has printed hard copies and is viewable on our website www.uaii.org. Copies and a detailed explanation of this notice are available to me upon request.

_____	_____	_____
Print Name of Consumer	Signature	Date

Or

_____	_____	_____
Print Name of Representative	Representative's Signature	Date

UAII Staff Only

Did the client request a copy of the NPP?

☐ **Yes**

- ☐ A summary version of NPP (copy)
- ☐ Detailed copy version of NPP (copy)

☐ **No**

- ☐ Patient refused a copy, but a brief explanation of the contents of the NPP was provided and the patient understands how they would be able to obtain a copy.
- ☐ Other: _____

_____	_____	_____
UAII Staff (Print)	Staff Signature	Date

Revised 11/3/13

United American Indian Involvement, Inc.

1125 West 6th Street, Suite 103 • Los Angeles, California 90017
Tel: (213) 202-3970 • Fax: (213) 202-3977 • uaii.org

Robert Sundance Family Wellness Center
1125 West 6th Street
Suite 103
Los Angeles, CA 90017
Tel: (213) 202-3970
Fax: (213) 975-9255

- *Inpatient/Outpatient Alcohol/Drug/Mental Health*
- *Nutrition*
- *Senior Services*
- *Sober Living*
- *Workforce Development Program*

Los Angeles American Indian Health Project
Tel: (213) 202-3970
Fax: (213) 202-3977

- *Primary Care Health Services*
- *Health Insurance - Enrollment Assistance*
- *Public Health and Case Management Services*
- *Diabetes Management and Prevention*
- *Nutrition Education*

Los Angeles American Indian Clubhouse
Tel: (213) 202-3976
Fax: (213) 202-3977

- *High School Program*
- *Prevention Workshops*
- *Summer Camps*
- *Camping, hiking, sports*
- *Field Trips*
- *Recreational/Social Activities*

Seven Generations Child and Family Counseling Services/System of Care
Tel: (213) 241-0979
Fax: (213) 241-0925
seven_generations@hotmail.com

- *Child & Family Counseling Crisis Interventions/Case Management/Parenting Training*
- *Domestic Violence & Sexual Assault Counseling*
- *Child Abuse Treatment Program*
- *Family Preservation*
- *Prevention and Aftercare*
- *Innovations*

www.uaii.org

RE: SEX OFFENDERS

For all using UAII services,

We at United American Indian Involvement, Inc. strive to keep a safe environment for everyone, while utilizing our services. Due to the fact that we have a high school at our facility, and that we provide services to children, youth and families, we require any person who is registered as a sex offender to voluntarily disclose their status when present at our facility or when receiving services.

If you are a registered sex offender, please make an appointment to see me with the proper documentation specifying your restrictions, so we can try to accommodate your service needs. Information received will be kept confidential or utilized on a need to know basis for relevant staff members. Disclosures of a sex offender status will not result in a refusal of services. However, the time, place, and manner of providing services may be regulated and scheduled to ensure the safety of UAII employees and other clients.

If you are a registered sex offender and you are identified through public information such as the Megan's Law Website, and you do not self-report, UAII has the right to refuse service.

Respectfully,

Jerimy Billy
Chief Executive Officer

Acknowledged by Applicant: _____ Date: _____

Staff Initials: _____ Revised: September 21, 2015

CAIR California Immunization Registry

Name: _____ DOB: _____ Mother's Name: _____

Last Name, First Middle Initial Last Name, First Middle Initial

Immunization Registry Notice to Patients and Parents (TB)

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an *immunization registry* to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It's your right to choose if you want shot/TB test records shared in the *California Immunization Registry*.

How Does a Registry Help You?

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots/TB tests children in their programs need
- Make sure children have all shots/TB tests needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth place
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots/TB tests

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number.

Patient and Parent Rights

It's your legal right to ask:

- not to share your (or your child's) registry shot/TB test records with others besides your doctor*
- not to get shot appointment reminders from your doctor's office
- to look at a copy of your or your child's shot/TB test records
- who has seen the records or to have the doctor change any mistakes

If you DO want your or your child's records in the registry, do nothing. You're all done.

If you DO NOT want your doctor's office to share your immunization/TB test information with other registry users, request a "*Decline or Start Sharing/Information Request Form*" from your doctor's office or download it from the CAIR website (http://cairweb.org/cair-forms/).

For more information, contact the CAIR Help Desk at 800-578-7889 or CAIRHelpDesk@cdph.ca.gov

Signature: _____ Today's Date: _____

(Your signature or parent or legal guardian)

** By law, public health officials can also look at the registry in the case of a public health emergency.*

American Indian/Alaska Native? Yes / No (circle one)

Name: _____ Date of Birth: _____ Date: _____

Address: _____ City: _____ Zip: _____ Phone: (_____) _____

ARE YOU AT RISK FOR TYPE 2 DIABETES?

American Diabetes Association®

Diabetes Risk Test

1 How old are you?

Less than 40 years (0 points)
40—49 years (1 point)
50—59 years (2 points)
60 years or older (3 points)

Write your score in the box.

2 Are you a man or a woman?

Man (1 point) Woman (0 points)

3 If you are a woman, have you ever been diagnosed with gestational diabetes?

Yes (1 point) No (0 points)

4 Do you have a mother, father, sister, or brother with diabetes?

Yes (1 point) No (0 points)

5 Have you ever been diagnosed with high blood pressure?

Yes (1 point) No (0 points)

6 Are you physically active?

Yes (0 points) No (1 point)

7 What is your weight status? *(see chart at right)*

Height	Weight (lbs.)		
4′ 10″	119-142	143-190	191+
4′ 11″	124-147	148-197	198+
5′ 0″	128-152	153-203	204+
5′ 1″	132-157	158-210	211+
5′ 2″	136-163	164-217	218+
5′ 3″	141-168	169-224	225+
5′ 4″	145-173	174-231	232+
5′ 5″	150-179	180-239	240+
5′ 6″	155-185	186-246	247+
5′ 7″	159-190	191-254	255+
5′ 8″	164-196	197-261	262+
5′ 9″	169-202	203-269	270+
5′ 10″	174-208	209-277	278+
5′ 11″	179-214	215-285	286+
6′ 0″	184-220	221-293	294+
6′ 1″	189-226	227-301	302+
6′ 2″	194-232	233-310	311+
6′ 3″	200-239	240-318	319+
6′ 4″	205-245	246-327	328+
	(1 Point)	(2 Points)	(3 Points)
	You weigh less than the amount in the left column (0 points)		

Add up your score.

If you scored 5 or higher:
You are at increased risk for having type 2 diabetes. However, only your doctor can tell for sure if you do have type 2 diabetes or prediabetes (a condition that precedes type 2 diabetes in which blood glucose levels are higher than normal). Talk to your doctor to see if additional testing is needed.

Adapted from Bang et al., Ann Intern Med 151:775-783, 2009.
Original algorithm was validated without gestational diabetes as part of the model.

Type 2 diabetes is more common in African Americans, Hispanics/Latinos, American Indians, and Asian Americans and Pacific Islanders.

For more information, visit us at www.diabetes.org or call 1-800-DIABETES

Visit us on Facebook
Facebook.com/AmericanDiabetesAssociation

Lower Your Risk

The good news is that you can manage your risk for type 2 diabetes. Small steps make a big difference and can help you live a longer, healthier life.

If you are at high risk, your first step is to see your doctor to see if additional testing is needed.

Visit diabetes.org or call 1-800-DIABETES for information, tips on getting started, and ideas for simple, small steps you can take to help lower your risk.

STOP DIABETES®

United American Indian Involvement

Staying Healthy Assessment

Adult (18 - 64 years)

HRN	CM / Program

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

Staff 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	N/A	Nutrition
2	Do you eat fruits and vegetables at least two times per day?	No	Yes	N/A	
3	Do you limit the amount of fried food or fast food that you eat?	No	Yes	N/A	
4	Are you easily able to get enough healthy food?	Yes	No	N/A	
5	Do you often eat too much or too little food?	Yes	No	N/A	
6	Are you concerned about your weight?	Yes	No	N/A	
7	Do you drink a soda, juice drink, sports or energy drink most days of the week?	Yes	No	N/A	
8	Do you brush and floss your teeth daily?	No	Yes	N/A	Dental Health
9	Do you have any tooth cavities or tooth pain?	No	Yes	N/A	
10	Do you exercise or spend time doing activities, such as walking, gardening, swimming for 1/2 hour a day?	Yes	No	N/A	Physical Activity
11	Do you feel safe where you live?	Yes	No	N/A	Safety
12	Have you had any car accidents lately?	Yes	No	N/A	
13	Have you been hit, slapped, kicked, or physically hurt by someone in the last year?	Yes	No	N/A	
14	Do you always wear a seat belt when driving or riding in a car?	Yes	No	N/A	
15	Do you keep a gun in your house or place where you live?	No	Yes	N/A	
16	Do you often feel sad, hopeless, angry, or worried?	No	Yes	N/A	Behavioral Health
17	Do you often have trouble sleeping?	No	Yes	N/A	
18	Have you ever had suicidal thoughts in the past year?	No	Yes	N/A	
19	Have you ever hurt yourself or attempted suicide?	No	Yes	N/A	

United American Indian Involvement

Staying Healthy Assessment

Adult (18 - 64 years)

20	Over the past two weeks how often have you been bothered by any of the following problems?					
	A) Do you often have little interest or pleasure in doing anything?	Not at all	Several Days	More than half the days	Nearly Every Day	
	B) Do you often feel down, depressed or hopeless?	Not at all	Several Days	More than half the days	Nearly Every Day	
21	Do you smoke cigarettes / e-cigarettes / vapes or chew tobacco?		No	Yes	N/A	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or place where you live?		No	Yes	N/A	
23	Please circle the answer that best descbribes:					
	I am currently being treated for an alcohol or other drug problem.		No	Yes	N/A	
	I was treated in the past for an alcohol or other drug problem		No	Yes	N/A	
	I have never been treated in the past for an alcohol or other drug problem		No	Yes	N/A	
24	In the past year, have you had:					
	(Men) 5 or more alcohol drinks in one day?		No	Yes	N/A	
	(Women) 4 or more alcohol drinks in one day?		No	Yes	N/A	
25	In the past 7 days, what types of drugs or alcohol have you used?					
	Types of Drug/Alcohol:					
	Route of Administration:					
26	How often during the last year have you felt you should cut down on your drinking or use of drugs?	Never	Monthly	Weekly	Almost Daily	
27	Have you ever become annoyed because some criticized your drinking?	Never	Monthly	Weekly	Almost Daily	
28	How often during the last year have you had feeling of guilt or remorse after drinking or use of drugs?	Never	Monthly	Weekly	Almost Daily	
29	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Monthly	Weekly	Almost Daily	
30	Has a friend, relative, or other health care worker been concerned about your drinking or use of drugs?		No	Yes	N/A	
31	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?		No	Yes	N/A	
32	Do you think you or your partner could be pregnant?		No	Yes	N/A	Sexual Issues
33	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?		No	Yes	N/A	
34	Have you or your partner(s) had sex without using birth control in the past year?		No	Yes	N/A	
35	Have you or your partner(s) had sex with other people in the past year?		No	Yes	N/A	

United American Indian Involvement

Staying Healthy Assessment

Adult (18 - 64 years)

36	Have you or your partner(s) had sex without a condom in the past year?		No	Yes	N/A	
37	Have you ever been forced or pressured to have sex?		No	Yes	N/A	
38	Do you have any other questions or concerns about your health?		No	Yes	N/A	Other Questions
	If yes, please describe:					
39	What type of diabetes do you have?	Date you were diagnosed:	Type I	Type II	Not Diabetic	
40	In the past year, have you had a dilated eye exam (eye drops in the eye to dilate the pupil)?		No	Yes	N/A	
	Date of last dilated eye exam: Results:		Normal	Abnormal		
41	In the past year, have you had a foot exam (Foot sensation test aka Filament Test)?		No	Yes	N/A	
	Date of last foot exam: Results:		Normal	Abnormal		
42	In the past year, have you had an EKG/ECG?		No	Yes	N/A	
	Date of last EKG/ECG exam: Results:		Normal	Abnormal	Borderline	
43	In the past year, have you had a Flu Shot (Vaccine to prevent influenza)?		No	Yes	N/A	
	Date:					
44	In the past year, have you had a Pneumovax vaccine (Vaccine to prevent pneumonia)?		No	Yes	N/A	
	Date:					
45	Have you ever had the Hepatitis B series completed?		No	Yes	N/A	
	Date:					
46	Have you ever had a Tetanus shot in the past 10 years?		No	Yes	N/A	
	Date:					
47	In the past year, have you had an HIV Test?		No	Yes	N/A	
	Date of Test:		Positive	Negative	N/A	
48	In the past year, have you had a TB (PPD) Test?		No	Yes	N/A	
	Date of Test:		Positive	Negative	N/A	
	If positive, have you had a Chest X-ray?	No / Yes / Date:				

Client Authorization

I acknowledge that the information provided is correct regarding my health and behaviors.

Client Name	Signature	Date

United American Indian Involvement

Staying Healthy Assessment

Adult (18 - 64 years)

FOR CARE TEAM USE ONLY

RD / PHN / Clinic Staff	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered		DV	Alcohol	Depression
☐ Nutrition					Negative			
☐ Physical Activity					Present			
☐ Safety					Past			
☐ Dental Health					Refused			
☐ Tobacco Exposure					Unable to screen			
Staff initials: _____ Date: _____					Staff initials: _____ Date: _____			

STAFF REVIEW (CM / PHN / CLINIC CARE PROVIDER)

Comments:			Did you meet with the client?
1st Reviewer Signature	Print Name	Date	If yes, were all the clients needs met at this time?
Comments:			Did you meet with the client?
2nd Reviewer Signature	Print Name	Date	If yes, were all the clients needs met at this time?