2021 Farmworker Outreach Health Assessment - Adol (12-17) | ORW: | Date:

Privacy*

My signature indicates that I understand that my privacy will be protected within this farmworker health network except in the following circumstancs: if harm is suspected of a minor, elderly, or disabled person.

Signature: _____

Demographics*

Name (first, last): _____ **Birth date**: _____ □ Est.

Preferred language: Span/ Engl/ Other: _____

Do you need an interpreter? Yes/ No

Worker typer: Migrant (□ H2A?)/ Seasonal/ Other

Hispanic or Latino? Yes/ No/ Decline

(If migrant) **Estimated departure date**: _____

Unaccompanied minor? Yes/ No

Race: □ White □ Black □ American Indian □ Asian □ Decline to answer

What sex were you assigned at birth? Male/ Female

What is your current gender identity? Man/ Woman/ Transgender man/ Transgender woman/ Other/ Decline to answer

Do you consider yourself to be: □ Heterosexual (not gay nor lesbian) □ Lesbian, gay, or homosexual □ Bisexual □ Something different □ Unsure □ Decline to answer?

Housing: Own/ Rent/ Grower-provided/ Homeless

Address: _____ **City**: _____

State: _____ **Zip code**: _____ **County**: _____

Health insurance: None / Medicaid / Medicare / Health Choice / Private **Family income** ($ amount): _____

Amount is per: week / 2 weeks/ month / year **# months worked** ____ **# familyl members**: _____

COVID-19*

In the last 2 weeks have you had fever, cough, sore throat, unusual fatigue, headache, chills, diarrhea, loss of taste or smell, or shortness of breath? □ Yes □ No _____

Do you live with someone or have you been around someone who has been diagnosed with COVID-19 in the last 2 weeks? □ Yes □ No _____

Have you received the COVID-19 vaccine? □ Yes □ No

1st dose date:_____ clinic: _____ manufacturer: _____

2nd dose date:_____ clinic: _____ manufacturer: _____

Health ed: ☐ Provided ☐ Follow up

Vaccine : ☐ Provided ☐ Referral ☐ Follow up ☐ Declined

Testing : ☐ Provided ☐ Referral ☐ Follow up ☐ Declined

Vitals

Blood pressure: _____ **Health ed:** ☐ Provided ☐ Follow up

If >120/80, offer health ed. If >140/90, offer referral. **Referral:** ☐ **Provided** ☐ **Follow up** ☐ **Declined**

General health

Is there something that worries you about your health? No/ Yes**:**_____

(If yes) **How can I help you with this problem?** _____

Have you ever been diagnosed with a medical condition? No/ Yes:_____

Are you taking (or should you be taking) medicines? No/ Yes:_____

Have you had a physical exam in the last two years in which you received vaccines? No/ Yes

If no, provide referral to primary care or health department.

Referral: ☐ Provided ☐ Follow up ☐ Declined *Diabetes, pregnancy, HTN, HIV, TB or abnormal cancer screen, consider MCN*

Occupational

Do you work in the fields? No/ Yes

(If yes) **Would you like more information on how to protect yourself at work?** (such as pesticides, heat stress, or something else) No/ Yes**:** _____

(If yes) **Do you worry about conditions at work?** (like unfair pay, pesticides exposure, or other illegal practices) No/ Yes**:** _____

Health ed: □ Provided □ Follow up

Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined**

Health ed topic: _____

BH

In the last 2 weeks, have you often felt little interest or desire to do things? No/ Yes

In the last 2 weeks, have you felt sad, depressed, or hopeless? No/ Yes

If yes to either question, offer a referral or full depression screen (RHS-15)
For positive RHS-15, offer referral

Referral: ☐ Provided ☐ Follow up ☐ Declined

RHS-15: ☐ Provided ☐ Follow up

Substance use

Do you drink alcohol, including beer? No/ Yes *If yes, complete 4 CAGE questions below.*

In the past year have you used an illegal drug or prescription medication for non-medical reasons? No/ Yes
(ex: the experience or feeling the drug causes) If yes, complete 4 CAGE questions below.

CAGE-AID

Have you ever felt that you should reduce your drug or alcohol use? .....No/ Yes
Have you ever felt bothered by criticism by other people about your drug or alcohol use? .....No/ Yes
Have you ever felt guilty or bad due to your drug or alcohol use? .....No/ Yes
Have you ever felt that you needed drugs or alcohol in the morning to calm your nerves or to help with a hangover? ..... No/ Yes
If yes to any of the 4 questions, provide referral.

Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined** **Health ed:** ☐ Provided ☐ Follow up ☐ Declined

CM

Does someone where you work or live threaten you or make you feel in danger? No/ Yes
Do you have any other worries or concerns? No/ Yes: _____

Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined**

Communication*

How can we communicate with you? *Ask patient to initial next to each below if OK.*

Cell number: _____ Teléfono fijo: _____
_____ OK to leave a message. _____ OK to leave a message.
_____ OK to leave a voicemail. _____ OK to leave a voicemail.
_____ OK to send a text (SMS) even though complete privacy is not guaranteed.
_____ OK to send a message through WhatsApp even though it may not be completely private.

Email address: _____
_____ OK to send a message.

How do you prefer that we communicate with you? *Mark preference.*

Addtl. Health Ed

Would you like more information on the following topics? *Circle those desired and check off if provided.*

□ Dental health □ Family planning □ Nutrition □ Drug or alcohol abuse
□ Diabetes □ Hypertension □ STIs/ HIV □ Other(s)_____
□ Emotional health □ Green Tobacco Sickness □ Smoking

Notes