#### 0 - 6 Months

Chil	ild's Name (first & last)  Date of Birth  Male				Today's Date			In Child/Day Care?  Yes No	
Pers	on Completing Form	☐ Parent ☐ Rel	lative 🔲 Frie	end Guardian Need Help with For				ed Help with Form?	
		Other (Specify	)					Yes No	
an a	se answer all the questions on this for inswer or do not wish to answer. Be s	octor if you ho	ave qu	estions a			Need Interpreter?  Yes No		
any	thing on this form. Your answers will	be protected as pa	rt of your med	dical re	ecord.			Clinic Use Only:	
1	Do you breastfeed your baby?		Yes	No	Ski	р	Nutrition		
2	Are you concerned about your bab	y's weight?		No	Yes	Ski	р	Physical Activity	
3	Does your baby watch any TV?		No	Yes	Ski	р			
4	Does your home have a working sa		Yes	No	Skip		Safety		
5	Have you turned your water temper (less than 120 degrees)?	w-warm	Yes	No	Ski	р			
6	If your home has more than one flo guards on the windows and gates f	•	safety	Yes	No	Ski	р		
7	Does your home have cleaning supmatches locked away?	and	Yes	No	Ski	р			
8	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?				No	Ski	р		
9	Do you always put your baby to sleep on her/his back?				No	Ski	р		
10	Do you always stay with your baby bathtub?	y when she/he is i	n the	Yes	No	Ski	р		

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

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
Nutrition					
Physical Activity					
Safety					
☐ Dental Health					
☐ Tobacco Exposure					☐ Patient Declined the SHA
PCP's Signature:		Print Nam	e:		Date:

#### 7 - 12 Months

Child's Name (first & last)  Date of Birth  Male					Today's Date			In Child/Day Care?  Yes No		
Pers	son Completing Form	☐ Parent ☐ Re						d Help with Form? Yes  No		
ansı	use answer all the questions on this for wer or do not wish to answer. Be sure thing on this form. Your answers will	Circle "Skip' or if you have	e quest	ions abo			Need Interpreter? Yes No Clinic Use Only:			
1	Do you breastfeed your baby?		Yes	No	Sk	ip	Nutrition			
2	Does your baby drink or eat 3 serv daily, such as formula, milk, chees tofu?	-	:	Yes	No	Sk	ip			
3	Are you concerned about your bab		No	Yes	Sk	ip	Physical Activity			
4	Does your baby watch any TV?		No	Yes	Sk	ip				
5	Does your home have a working s	moke detector?		Yes	No	Sk	ip	Safety		
6	Have you turned your water temper (less than 120 degrees)?	erature down to lo	w-warm	Yes	No	Sk	ip			
7	If your home has more than one fleguards on the windows and gates to	safety	Yes	No	Sk	ip				
8	Does your home have cleaning supmatches locked away?	and	Yes	No	Sk	ip				
9	Does your home have the phone n Control Center (800-222-1222) po	i	Yes	No	Sk	ip				
10	Do you always put your baby to sl	eep on her/his bac	ck?	Yes	No	Sk	ip			

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

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
□ Nutrition					
Physical Activity					
Safety					
☐ Dental Health					
☐ Tobacco Exposure					☐ Patient Declined the SHA
PCP's Signature:		Print Nam	e:		Date:

### 1 -2 Years

Chil	hild's Name (first & last)  Date of Birth  Male			Today's Date			In Child/Day Care?		
Pers	son Completing Form	Parent Re	lative 🗌 Fri	iend Guardian Need Help with Form?					
an a	use answer all the questions on this for Inswer or do not wish to answer. Be s Thing on this form. Your answers will	estions a		Need Interpreter?					
1	Do you breastfeed your child?	Yes	No	Ski	p Nutrition				
2	Does your child drink or eat 3 serv daily, such as milk, cheese, yogurt	•		Yes	No	Ski	p		
3	Does your child eat fruits and vege per day?	etables at least two	o times	Yes	No	Ski	p		
4	Does your child eat high fat foods, ice cream, or pizza more than once		ds, chips,	No	Yes	Ski	p		
5	Does your child drink more than o juice per day?	No	Yes	Ski	p				
6	Does your child drink soda, juice of drinks, or other sweetened drinks in		No	Yes	Ski				
7	Does your child play actively mos	?	Yes	No	Ski	p Physical Activity			
8	Are you concerned about your chil	ld's weight?		No	Yes	Ski	p		
9	Does your child watch TV or play	video games?		No	Yes	Ski			
10	Does your home have a working s	moke detector?		Yes	No	Ski	p Safety		
11	Have you turned your water temper (less than 120 degrees)?	w-warm	Yes	No	Ski	р			
12	If your home has more than one floguards on the windows and gates f	Yes	No	Ski	p				
13	Does your home have cleaning supmatches locked away?	Yes	No	Ski	р				
14	Does your home have the phone no Control Center (800-222-1222) po			Yes	No	Ski	р		

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

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:				
Nutrition									
☐ Physical Activity									
Safety									
☐ Dental Health									
☐ Tobacco Exposure					☐ Patient Declined the SHA				
PCP's Signature		Pri	int Name:		Date:				
	SHA ANNUAL REVIEW								
PCP's Signature		Pr	int Name:		Date:				

### 3 - 4 Years

Chil	Child's Name (first & last)  Date of Birth  Male					e In	In Child/Day Care?	
Pers	son Completing Form	elative	iend Guardian Need Help with Form?  Yes No					
an c	ase answer all the questions on this fo answer or do not wish to answer. Be s thing on this form. Your answers will	estions a		Need Interpreter?  Yes No  Clinic Use Only:				
1	Does your child drink or eat 3 serv daily, such as milk, cheese, yogurt	_	:	Yes	No	Skip	Nutrition	
2	Does your child eat fruits and vegoper day?	etables at least tw	o times	Yes	No	Skip		
3	Does your child eat high fat foods ice cream, or pizza more than once		ods, chips,	No	Yes	Skip		
4	Does your child drink more than of juice per day?	one small cup (4 –	6 oz. cup)	No	Yes	Skip		
5	Does your child drink soda, juice drinks, or other sweetened drinks	No	Yes	Skip				
6	Does your child play actively mos	Yes	No	Skip	Physical Activity			
7	Are you concerned about your chi		No	Yes	Skip			
8	Does your child watch TV or play hours per day?	video games less	than 2	Yes	No	Skip		
9	Does your home have a working s	moke detector?		Yes	No	Skip	Safety	
10	Have you turned your water temporal (less than 120 degrees)?	erature down to lo	ow-warm	Yes	No	Skip		
11	If your home has more than one fl guards on the windows and gates	safety	Yes	No	Skip			
12	Does your home have cleaning sumatches locked away?	Yes	No	Skip				
13	Does your home have the phone n Control Center (800-222-1222) po	Yes	No	Skip				
14	Do you always stay with your chil bathtub?	Yes	No	Skip				
15	Do you always place your child in the back seat?	a forward facing	car seat in	Yes	No	Skip		

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

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:			
Nutrition								
Physical Activity								
Safety								
☐ Dental Health								
Tobacco Exposure					☐ Patient Declined the SHA			
PCP's Signature		P	rint Name:		Date:			
			SHA ANNUAL	REVIEW				
PCP's Signature		F	Print Name:		Date:			
PCP's Signature		F	rint Name:		Date:			

### 5 - 8 Years

Chil	ild's Name (first & last)  Date of Birth  Male				Date	Grade in School?	
Per	son Completing Form	Parent Rel	ative 🗌 Frier	ıd 🗌 Gu	ardian	School	Attendance
		Regula	r? 🗌 Yes 🗌 No				
an c	ase answer all the questions on t answer or do not wish to answer ut anything on this form. Your a	S	Need Interpreter?  Yes No  Clinic Use Only:				
1	Does your child drink or eat 3 daily, such as milk, cheese, y	_		Yes	No	Skip	Nutrition
2	Does your child eat fruits and per day?	l vegetables at leas	t two times	Yes	No	Skip	
3	Does your child eat high fat fice cream, or pizza more than		foods, chips,	No	Yes	Skip	
4	Does your child drink more the juice per day?	nan one small cup	No	Yes	Skip		
5	Does your child drink soda, ju energy drinks, or other sweets week?		No	Yes	Skip		
6	Does your child exercise or p week?	Yes	No	Skip	Physical Activity		
7	Are you concerned about you	r child's weight?		No	Yes	Skip	
8	Does your child watch TV or hours per day?	play video games	less than 2	Yes	No	Skip	
9	Does your home have a work	ing smoke detector	r?	Yes	No	Skip	Safety
10	Have you turned your water to (less than 120 degrees)?	emperature down	to low-warm	Yes	No	Skip	
11	Does your home have the pho Control Center (800-222-122	Yes	No	Skip			
12	Do you always place your child in a booster seat in the back seat (or use a seat belt if your child is over 4'9")?				No	Skip	
13	Does your child spend time n lake?	No	Yes	Skip			
14	Does your child spend time in	n a home where a g	gun is kept?	No	Yes	Skip	

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

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:		
Nutrition							
Physical Activity							
Safety							
☐ Dental Health							
☐ Tobacco Exposure					☐ Patient Declined the SHA		
PCP's Signature	Print Name:				Date:		
			SHA ANNUAL	REVIEW			
PCP's Signature		Pr	int Name:		Date:		
PCP's Signature Print Name:					Date:		
PCP's Signature		Pr	int Name:		Date:		

### 9 - 11 Years

Chil	ild's Name (first & last)  Date of Birth  Male			Today's	Today's Date		Grade in School:	
Pers	Person Completing Form Parent Relative Friend					Schoo	l Attendance	
		Regula	ar? Yes No					
ans	ase answer all the questions on this wer or do not wish to answer.  Be s thing on this form.  Your answers v	Need Interpreter?  Yes No  Clinic Use Only:						
1	Does your child drink or eat 3 s daily, such as milk, cheese, you	Yes	No	Skip	Nutrition Nutrition			
2	Does your child eat fruits and v per day?	regetables at least	two times	Yes	No	Skip		
3	Does your child eat high fat foo ice cream, or pizza more than o		foods, chips,	No	Yes	Skip		
4	Does your child drink more that day?	n one cup (8 oz.)	of juice per	No	Yes	Skip		
5	Does your child drink soda, juidrinks, or other sweetened drin	No	Yes	Skip				
6	Does your child exercise or play sports most days of the week?				No	Skip	Physical Activity	
7	Are you concerned about your child's weight?				Yes	Skip		
8	Does your child watch TV or play video games less than 2 hours per day?				No	Skip		
9	Does your home have a working	g smoke detector?	?	Yes	No	Skip	Safety	
10	Does your home have the phon Control Center (800-222-1222)			Yes	No	Skip		
11	Does your child always use a so use a booster seat if under 4'9"		seat (or	Yes	No	Skip		
12	Does your child spend time neal lake?	ar a swimming poo	ol, river, or	No	Yes	Skip		
13	Does your child spend time in a	a home where a gu	ın is kept?	No	Yes	Skip		
14	Does your child spend time with anyone who carries a gun, knife, or other weapon?				Yes	Skip		
15	Does your child always wear a helmet when riding a bike, skateboard, or scooter?				No	Skip		
16	Has your child ever witnessed oviolence?	or been a victim of	No	Yes	Skip			
17	Has your child been hit or has y past year?	your child hit som	eone in the	No	Yes	Skip		

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

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:		
Nutrition							
☐ Physical activity							
Safety							
☐ Dental Health							
☐ Mental Health							
Alcohol, Tobacco, Drug Use							
Sexual Issues					☐ Patient Declined the SHA		
PCP's Signature:		Print	Name:		Date:		
		-					
SHA ANNUAL REVIEW							
PCP's Signature:		Print	Name:		Date:		
CP's Signature: Print Name:					Date:		

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### 12 - 17 Years

Nar	ne (first & last)	Date of Birth Female Male			Today's Date		Grade in School:	
Pers	son Completing Form	Parent Rela	tive	Gua	ardian	School Attendance		
	. 0	_		Regular	r? 🗌 Yes 🔲 No			
	use answer all the questions on this wer or do not wish to answer. Be su	-				Need Interpreter?		
	thing on this form. Your answers w			-		-	Clinic Use Only:	
1	Do you drink or eat 3 servings of comilk, cheese, yogurt, soy milk, or to		ly, such as	Yes	No	Skip	Nutrition	
2	Do you eat fruits and vegetables at	least 2 times per day	?	Yes	No	Skip		
3	Do you eat high fat foods, such as a pizza more than once per week?	fried foods, chips, ice	cream, or	No	Yes	Skip		
4	Do you drink more than 12 oz. (1 s sports drink, energy drink, or sweet		uice drink,	No	Yes	Skip		
5	Do you exercise or play sports mos	at days of the week?		Yes	No	Skip	Physical Activity	
6	Are you concerned about your weig	ght?		No	Yes	Skip		
7	Do you watch TV or play video ga	mes less than 2 hours	per day?	Yes	No	Skip		
8	Does your home have a working sn		Yes	No	Skip	Safety		
9	Does your home have the phone nu (800-222-1222) posted by your pho	Control Center	Yes	No	Skip			
10	Do you always wear a seatbelt whe		Yes	No	Skip			
11	Do you spend time in a home wher			No	Yes	Skip		
12	Do you spend time with anyone wh weapon?	no carries a gun, knife	e, or other	No	Yes	Skip		
13	Do you always wear a helmet when scooter?	n riding a bike, skateb	ooard, or	Yes	No	Skip		
14	Have you ever witnessed abuse or	violence?		No	Yes	Skip		
15	Have you been hit, slapped, kicked (or have you hurt someone) in the I		y someone	No	Yes	Skip		
16	Have you ever been bullied or felt neighborhood (or been cyber-bullie	your	No	Yes	Skip			
17	Do you brush and floss your teeth of	daily?		Yes	No	Skip	Dental Health	
18	Do you often feel sad, down, or hopeless?				Yes	Skip	Mental Health	
19	Do you spend time with anyone wh		No	Yes	Skip	Alcohol, Tobacco, Drug Use		
20	Do you smoke cigarettes or chew to	obacco?		No	Yes	Skip		
21	Do you use or sniff any substance t cocaine, crack, Methamphetamine			No	Yes	Skip		

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22	Do you use medicines not prescribed for you?	No	Yes	Skip	
23	Do you drink alcohol once a week or more?	No	Yes	Skip	
24	If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes	Skip	
25	Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes	Skip	
You	ir answers about sex and family planning cannot be shared with anyone, inc	cluding y	our pare	nts, witho	• •
27	Have you ever been forced or pressured to have sex?	No	Yes	Skip	Sexual Issues
28	Have you ever had sex (oral, vaginal, or anal)? <i>If no, skip to question</i> 35.	No	Yes	Skip	
29	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
30	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
31	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
32	The last time you had sex, did you use birth control?	Yes	No	Skip	
33	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
34	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip	
35	Do you have concerns about liking someone of the same sex?	No	Yes	Skip	
36	Do you have any other questions or concerns about your health?	Yes	No	Skip	

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
Nutrition					
☐ Physical activity					
Safety					
☐ Dental Health					
☐ Mental Health					
Alcohol, Tobacco, Drug Use					
Sexual Issues					☐ Patient Declined the SHA
PCP's Signature:		Print Name:			Date:
		SHA	A ANNUAL REV	IEW	
PCP's Signature:		Print Name:			Date:
PCP's Signature:		Print Name:			Date:
PCP's Signature:		Print Name:			Date:
PCP's Signature:		Print Name:			Date:

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#### Adult

Pati	atient's Name (first & last)  Date of Birth					Today	Today's Date	
			Ма	le				
Per	son Completing Form (if patient needs help) $\Box$ Family	y Membei	r 🗌 Fr	iend [	Other	Need l	nelp with form?	
Please specify:								
	ase answer all the questions on this form as best you		-				Need Interpreter?	
	answer or do not wish to answer. Be sure to talk to t thing on this form. Your answers will be protected a			-		about	Yes No Clinic Use Only:	
uny				euicui i	ecoru.		Nutrition	
1	Do you drink or eat 3 servings of calcium-rich f such as milk, cheese, yogurt, soy milk, or tofu?	oods dai	ıy,	Yes	No	Skip		
2	Do you eat fruits and vegetables every day?			Yes	No	Skip		
3	Do you limit the amount of fried food or fast foo eat?	od that ye	ou	Yes	No	Skip		
4	Are you easily able to get enough healthy food?			Yes	No	Skip		
5	Do you drink a soda, juice drink, sports or energe days of the week?	No	Yes	Skip				
6	Do you often eat too much or too little food?		No	Yes	Skip			
7	Are you concerned about your weight?			No	Yes	Skip		
8	Do you exercise or spend time doing activities, walking, gardening, swimming for ½ hour a day			Yes	No	Skip	Physical Activity	
9	Do you feel safe where you live?			Yes	No	Skip	Safety	
10	Have you had any car accidents lately?			No	Yes	Skip		
11	Have you been hit, slapped, kicked, or physicall someone in the last year?	y hurt by	<b>y</b>	No	Yes	Skip		
12	Do you always wear a seat belt when driving or car?	ı a	Yes	No	Skip			
13	Do you keep a gun in your house or place where	you live	e?	No	Yes	Skip		
14	Do you brush and floss your teeth daily?			Yes	No	Skip	Dental Health	
15	Do you often feel sad, hopeless, angry, or worrie	ed?		No	Yes	Skip	Mental Health	
16	Do you often have trouble sleeping?			No	Yes	Skip		
17	Do you smoke or chew tobacco?			No	Yes	Skip	Alcohol, Tobacco, Drug Use	
18	Do friends or family members smoke in your how where you live?	ouse or p	lace	No	Yes	Skip		

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19	Do you drink 2 or more alcoholic drinks per day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
Nutrition					
☐ Physical activity					
Safety					
☐ Dental Health					
☐ Mental Health					
Alcohol, Tobacco, Drug Use					
Sexual Issues					☐ Patient Declined the SHA
PCP's Signature: Print Name:					Date:
			HA ANNUAL	REVIEW	
PCP's Signature:		Print	Name:		Date:
PCP's Signature:		Print	Name:		Date:
PCP's Signature: Print Name:					Date:
PCP's Signature: Print Name:					Date:

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### Senior

Patient's Name (first & last)		Date of Birth	☐ Female		Today's Date	
			☐ Male			
Person Completing Form (if patient needs help) Family Member Frie			end 🗌 Other		Need help with form?	
					☐ Yes ☐ No	
	se answer all the questions on this form as		Need Interpreter?			
answer or do not wish to answer. Be sure to talk to the doctor if you have q						Yes No
uny	anything on this form. Your answers will be protected as part of your medi			mu.		Clinic Use Only: Nutrition
1	Do you drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?			No	Skip	
2	Do you eat fruits and vegetables every day?			No	Skip	
3	Do you limit the amount of fried food of	Yes	No	Skip		
4	Are you easily able to get enough health	Yes	No	Skip		
5	Do you drink a soda, juice drink, sports or energy drink most days of the week?			Yes	Skip	
6	Do you often eat too much or too little food?			Yes	Skip	
7	Do you have difficulty chewing or swallowing?			Yes	Skip	
8	Are you concerned about your weight?	No	Yes	Skip		
9	Do you exercise or spend time doing activities, such as walking, gardening, or swimming for at least ½ hour a day?			No	Skip	Physical Activity
10	Do you feel safe where you live?			No	Skip	Safety
11	Do you often have trouble keeping track of your medicines?			Yes	Skip	
12	Are family members or friends worried about your driving?			Yes	Skip	
13	Have you had any car accidents lately?			Yes	Skip	
14	Do you sometimes fall and hurt yourself, or is it hard to get up?			Yes	Skip	
15	Have you been hit, slapped, kicked, or physically hurt by someone in the past year?			Yes	Skip	
16	Do you keep a gun in your house or place where you live?			Yes	Skip	
17	Do you brush and floss your teeth daily?			No	Skip	Dental Health
18	Do you often feel sad, hopeless, angry,	No	Yes	Skip	Mental Health	
19	Do you often have trouble sleeping?	No	Yes	Skip		

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20	Do you or others think that you are having trouble remembering things?	No	Yes	Skip	
21	Do you smoke or chew tobacco?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Do friends or family members smoke in your house or where you live?	No	Yes	Skip	
23	Do you drink 2 or more alcoholic drinks per day?	No	Yes	Skip	
24	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
25	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	Sexual Issues
26	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
27	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
28	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
29	Do you have someone to help you make decisions about your health and medical care?	Yes	No	Skip	Independent Living
30	Do you need help bathing, eating, walking, dressing, or using the bathroom?	No	Yes	Skip	
31	Do you have someone to call when you need help in an emergency?	Yes	No	Skip	
32	Do you have other questions or concerns about your health?	Yes	No	Skip	

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:			
Nutrition								
Physical activity								
Safety								
☐ Dental Health								
☐ Mental Health								
Alcohol, Tobacco, Drug Use								
☐ Sexual Issues								
☐ Independent Living					☐ Patient Declined the SHA			
PCP's Signature:	Print Name:				Date:			
SHA ANNUAL REVIEW								
PCP's Signature:	Print Name:				Date:			
PCP's Signature:	Print Name:				Date:			
PCP's Signature:	Print Name:				Date:			
PCP's Signature:	Print Name:				Date:			