

2023 Farmworker Outreach Health Assessment - Adult (English)		ORW:	Date:
Optional	<b>FHASES ID:</b> _____ <b>Cohort:</b> _____ <b>Employer:</b> _____		
Privacy	My signature indicates that I understand that my privacy will be protected within this farmworker health network except in the following circumstances: if harm is suspected of a minor, elderly, or disabled person.  Signature: _____		
Demographics	<b>Name (first, last):</b> _____ <b>Birth date:</b> ____/____/____ <input type="checkbox"/> Est. <i>mm/dd/yyyy</i> <b>Preferred language:</b> Span/ Engl/ Other: _____ <b>Do you need an interpreter?</b> Yes/ No <b>Worker type:</b> Migrant ( <input type="checkbox"/> H2A? <input type="checkbox"/> H2B?)/ Seasonal/ Other <b>Hispanic or Latino?</b> Yes/ No/ Decline <i>(If migrant) Estimated departure date:</i> _____ <b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian Native <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Decline to answer <b>What sex were you assigned at birth?</b> Male/ Female <b>What is your current gender identity?</b> Man/ Woman/ Transgender man/ Transgender woman/ Other/ Decline to answer <b>Do you consider yourself to be:</b> <input type="checkbox"/> Heterosexual (not gay nor lesbian) <input type="checkbox"/> Lesbian, gay, or homosexual <input type="checkbox"/> Bisexual <input type="checkbox"/> Something different <input type="checkbox"/> Unsure <input type="checkbox"/> Decline to answer? <b>Housing:</b> Own/ Rent/ Grower-provided/ Homeless <b>Address:</b> _____ <b>City:</b> _____ <b>US veteran?</b> Sí/ No <b>State:</b> _____ <b>Zip code:</b> _____ <b>County:</b> _____ <b>Health insurance:</b> None / Medicaid / Medicare / Health Choice / Private <b>Family income (\$ amount):</b> _____ <b>Amount is per:</b> week / 2 weeks/ month / year <b># months worked</b> ____ <b># family members:</b> _____		
Communication	<b>How can we communicate with you?</b> <i>Ask patient to initial next to each below if OK.</i> Cell number: _____ _____ OK to leave a message with another person. _____ 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. WhatsApp number (if different): _____ <b>How do you prefer that we communicate with you?</b> <i>Circle preference.</i>		<b>Emergency contact (optional)</b> Full name: _____ Phone number: _____ Relationship: _____
COVID-19	<b>Have you received the COVID-19 vaccine?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Have you received the bivalent booster?</b> (Available in the US since Sept. 2022) <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "no" to either of the above, offer a referral.</i> 1st dose date: _____ clinic: _____ manufacturer: _____ 2nd dose date: _____ clinic: _____ manufacturer: _____ Booster date: _____ clinic: _____ manufacturer: _____ Booster date: _____ clinic: _____ manufacturer: _____ <b>Health ed:</b> <input type="checkbox"/> Provided <input type="checkbox"/> Follow up <b>Vaccine :</b> <input type="checkbox"/> Provided <input type="checkbox"/> Referral <input type="checkbox"/> Follow up <input type="checkbox"/> Declined <b>Testing :</b> <input type="checkbox"/> Provided <input type="checkbox"/> Referral <input type="checkbox"/> Follow up <input type="checkbox"/> Declined		
Vitals	<b>Blood pressure:</b> _____ <b>Health ed:</b> <input type="checkbox"/> Provided <input type="checkbox"/> Follow up <i>If &gt;120/80, offer health ed. If &gt;140/90, offer referral.</i> <b>Referral:</b> <input type="checkbox"/> Provided <input type="checkbox"/> Follow up <input type="checkbox"/> Declined		
General health	<b>Is there something that worries you about your health? No/ Yes:</b> _____ <i>(If yes) How can I help you with this problem?</i> _____ <b>Have you ever been diagnosed with a medical condition? No/ Yes:</b> _____ <b>Are you taking (or should you be taking) medicines? No/ Yes:</b> _____ <b>Referral:</b> <input type="checkbox"/> Provided <input type="checkbox"/> Follow up <input type="checkbox"/> Declined <i>*Schedule a diabetes departure visit, if needed:</i> _____		

Occupational	<p><b>Do you work in the fields? No/ Yes</b></p> <p><i>(If yes) Do you worry about conditions at work? (like unfair pay, pesticides exposure, or other illegal practices)</i>  <b>No/ Yes:</b> _____</p> <p><i>(If yes) Would you like more information on how to protect yourself at work? (such as pesticides, heat stress, or something else)</i> <b>No/ Yes:</b> _____</p> <p><b>Health ed:</b>    <input type="checkbox"/> Provided    <input type="checkbox"/> Follow up</p> <p>Referral:    <input type="checkbox"/> <b>Provided</b>    <input type="checkbox"/> <b>Follow up</b>    <input type="checkbox"/> <b>Declined</b>    Health ed topic: _____</p>																
MH	<p><b>In the last 2 weeks, have you often felt little interest or desire to do things? (PHQ-2) No/ Yes</b></p> <p><b>In the last 2 weeks, have you felt sad, depressed, or hopeless? (PHQ-2) No/ Yes</b></p> <p><i>If yes to either question, offer a behavioral health or primary care referral and full depression screen (PHQ-9)</i></p> <p><b>Referral:</b> <input type="checkbox"/> Provided <input type="checkbox"/> Follow up <input type="checkbox"/> Declined</p> <p><b>PHQ-9:</b>    <input type="checkbox"/> Provided <input type="checkbox"/> Follow up</p> <p><b>Health ed:</b>    <input type="checkbox"/> Provided    <input type="checkbox"/> Follow up</p>																
Substance use	<p><b>Do you drink alcohol, including beer? No/ Yes</b> <i>If yes, complete 4 CAGE questions below.</i></p> <p><b>In the past year have you used an illegal drug or prescription medication for non-medical reasons? No/ Yes</b>  <i>(ex: the experience or feeling the drug causes) If yes, complete 4 CAGE questions below.</i></p> <div style="border: 1px solid black; padding: 5px;"> <p><b>CAGE-AID</b></p> <p>Have you ever felt that you should reduce your drug or alcohol use? .....No/ Yes</p> <p>Have you ever felt bothered by criticism by other people about your drug or alcohol use? .....No/ Yes</p> <p>Have you ever felt guilty or bad due to your drug or alcohol use? .....No/ Yes</p> <p>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</p> <p><i>If yes to any of the 4 questions, provide referral.</i></p> </div> <p>Referral:    <input type="checkbox"/> <b>Provided</b>    <input type="checkbox"/> <b>Follow up</b>    <input type="checkbox"/> <b>Declined</b>    <b>Health ed:</b>    <input type="checkbox"/> Provided <input type="checkbox"/> Follow up <input type="checkbox"/> Declined</p>																
CM	<p><b>Does someone where you work or live threaten you or make you feel in danger? No/ Yes</b></p> <p><b>Do you have any other worries or concerns? No/ Yes:</b> _____</p> <p>Referral:    <input type="checkbox"/> <b>Provided</b>    <input type="checkbox"/> <b>Follow up</b>    <input type="checkbox"/> <b>Declined</b></p>																
Addtl. Health Ed	<p><b>Would you like more information on the following topics? Circle those desired and check off if provided.</b></p> <table border="0"> <tr> <td><input type="checkbox"/> COVID-19</td> <td><input type="checkbox"/> Emergency preparedness</td> <td><input type="checkbox"/> Internet access</td> <td><input type="checkbox"/> Telehealth services</td> </tr> <tr> <td><input type="checkbox"/> Dental health</td> <td><input type="checkbox"/> Emotional health</td> <td><input type="checkbox"/> Nutrition</td> <td><input type="checkbox"/> Other(s) _____</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Green Tobacco Sickness</td> <td><input type="checkbox"/> STIs/ HIV</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Drug or alcohol abuse</td> <td><input type="checkbox"/> Hypertension</td> <td><input type="checkbox"/> Smoking</td> <td></td> </tr> </table>	<input type="checkbox"/> COVID-19	<input type="checkbox"/> Emergency preparedness	<input type="checkbox"/> Internet access	<input type="checkbox"/> Telehealth services	<input type="checkbox"/> Dental health	<input type="checkbox"/> Emotional health	<input type="checkbox"/> Nutrition	<input type="checkbox"/> Other(s) _____	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Green Tobacco Sickness	<input type="checkbox"/> STIs/ HIV		<input type="checkbox"/> Drug or alcohol abuse	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Smoking	
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