	2025 Farmworker Outreach Health Assessment - Adol (12-17)	ORW:	Date:
Optional	FHASES ID: _____ **Cohort:** _____ **Employer:** _____		

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.
mm/dd/yyyy

Preferred language: Span/ Engl/ Other: _____

Do you need an interpreter? Yes/ No

Worker type: Migrant (□ H2A? □ H2B?))/ Seasonal/ Other

(*If migrant*) **Estimated departure date**: _____   **Unaccompanied?** Yes / No

Are you of Hispanic, Latino, or Spanish origin? *Mark all that apply.*
□ Yes, Mexican, Mexican Am., Chicano   □ Yes, Puerto Rican   □ Yes, Cuban
□ Yes, another Hispanic, Latino, or Spanish origin   □ No, not of Hispanic, Latino, or Spanish origin   □ Decline to answer

What is your race? *Mark all that apply.*
□ White   □ Vietnamese □ Korean   □ American Indian or Alaska Native
□ Black or African Am.   □ Filipino   □ Samoan   □ Native Hawaiian
□ Some other race   □ Chamorro   □ Japanese   □ Asian Indian
□ Decline to annswer   □ Chinese   □ Other Asian □ Other Pacific Islander

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** _____   **# family members**: _____

Communication

How can we communicate with you?
Ask patient to initial next to each below if OK.
     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): _____
  How do you prefer that we communicate with you? *Circle preference.*

Emergency contact (optional)
Full name: _____
Phone number: _____
Relationship: _____

Vitals

Blood pressure: _____

If >120/80, offer health ed. If >140/90, offer referral.

Health ed: □ Provided   □ Follow up

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:_____

Are you interesed in behavioal health services? No/ Yes:_____

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

*Schedule a diabetes departure visit, if needed: _____

COVID-19

Do you have any questions about COVID-19? □ Yes □ No

Health ed: □ Provided   □ Follow up

Vaccine ed: □ Provided   □ Referral   □ Follow up   □ Declined

Self-test kit :   □ Provided   □ Referral   □ Follow up   □ Declined

Occupational	**Do you work in the fields? No/ Yes** *(If yes)* **Do you worry about conditions at work?** (like unfair pay, pesticides exposure, or other illegal practices) **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:** _____ **Health ed:** ☐ Provided ☐ Follow up Referral: ☐ **Provided** ☐ **Follow up** ☐ **Declined** Health ed topic: _____

MH

Over the last 2 weeks, how often have you been bothered by any of the following problems? (PHQ-2)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

If yes to either question, offer a behavioral health or primary care referral and full depression screen (PHQ-9: Modified for Teens)

Referral: ☐ Provided ☐ Follow up ☐ Declined
PHQ-9: ☐ Provided ☐ Follow up
Health ed: ☐ Provided ☐ Follow up

Substance use	**In the last year, have you smoked or used tobacco products? No / Yes** *If yes, provide education &* **QUITLINE #: 1-855-335-3569** **Health ed**: ☐ Provided ☐ Follow up ☐ Declined **In the last year, have you had more than 4 alcoholic drinks in one sitting? No / Yes** *If yes, provide education* **Health ed**: ☐ Provided ☐ Follow up ☐ Declined ***In the last year, have you used any other substane (including marijuana, cocaine, anphetamies [crystal] or opioids)?*** **No / Yes** *If yes, provide education* **Health ed**: ☐ Provided ☐ Follow up ☐ Declined *If yes to any question above:* **Are you interested in support to help you reduce your use of substances including tobacco and alcohol? No / Yes** *If yes, provide referral to primary care or behavioral health services.* Referral: ☐ **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**
Addtl. Health Ed	**Would you like more information on the following topics?** *Circle those desired and check off if provided.* ☐ COVID-19 ☐ Emergency preparedness ☐ Internet access ☐ Telehealth services ☐ Dental health ☐ Emotional health ☐ Nutrition ☐ Other(s)_____ ☐ Diabetes ☐ Green Tobacco Sickness ☐ STIs/ HIV ☐ Drug or alcohol abuse ☐ Hypertension ☐ Smoking
Notes	