El Puente A La Salud
The Bridge To Health
Community Health Advocate

Chronic Disease Prevention and Health Promotion Section
Nevada Division of Public and Behavioral Health

HOUSEHOLD CLIENT REGISTRATION FORM

CLIENT ID:

Please fill out the following information for all:

- Partner & Children
- Others living in your home

1. Name: _____ _____ / ____ / ____ / _____
   LAST FIRST MIDDLE DATE OF BIRTH ETHNICITY

   Relationship: _____ Client ID: _____

2. Name: _____ _____ / ____ / ____ / _____
   LAST FIRST MIDDLE DATE OF BIRTH ETHNICITY

   Relationship: _____ Client ID: _____

3. Name: _____ _____ / ____ / ____ / _____
   LAST FIRST MIDDLE DATE OF BIRTH ETHNICITY

   Relationship: _____ Client ID: _____

4. Name: _____ _____ / ____ / ____ / _____
   LAST FIRST MIDDLE DATE OF BIRTH ETHNICITY

   Relationship: _____ Client ID: _____

5. Name: _____ _____ / ____ / ____ / _____
   LAST FIRST MIDDLE DATE OF BIRTH ETHNICITY

   Relationship: _____ Client ID: _____

6. Name: _____ _____ / ____ / ____ / _____
   LAST FIRST MIDDLE DATE OF BIRTH ETHNICITY

   Relationship: _____ Client ID: _____

Comments:

_____

_____

_____

_____

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CONSENT FOR SERVICES

CLIENT ID:

CONSENT TO SERVICES: I hereby consent to and authorize such services as prescribed and fully explained to me by the Community Health Worker (CHW). It is not possible to make guarantees concerning the results of services. I acknowledge no such guarantee has been made to me. I understand I will have the opportunity to discuss any and all care and/or services proposed to me with the CHW and I may refuse to consent for care services if I do not want to proceed with such course of services. I will provide the CHW with accurate information regarding my medical, sexual, drug and/or alcohol history, and personal or social concerns which may impact my health or medical care to ensure proper service, care, and referral for needed services.

I understand that if I am more than 15 minutes late for my appointment or home visit I may not be seen and will need to reschedule my appointment. I am responsible for notifying the appropriate CHW – preferably at least 24 hours in advance – if I am unable to keep my scheduled appointment. To the best of my ability, I will be an active participant in my care. I am responsible for reporting any changes in my health status to my CHW so that I can receive prompt and appropriate education and referral services.

_____ INITIAL

If during an appointment of home visit with a CHW my situation is an emergency I will call 911 for assistance or go to the nearest emergency room.

_____ INITIAL

I HAVE CAREFULLY READ AND FULLY UNDERSTAND THIS CONSENT AND AGREEMENT. I HAVE RECEIVED A COPY OF THIS CONSENT/AGREEMENT, AND AM DULY AUTHORIZED TO EXECUTE THE ABOVE AND ACCEPT THE TERMS AS DESCRIBED. I UNDERSTAND THIS CONSENT/AGREEMENT IS EFFECTIVIE UNTIL REVOKED IN WRITING.

_____ _____

Signature of Client/Parent/Guardian/Legal Representative — Date

_____ _____

Witness — Date

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

CLIENT ID:

This authorization authorizes the release of Protected Health Information pursuant to CFR Parts 160 and 164

This is to certify that permission is herby granted to release information as follows:

Name of Client: _____ **Birth Date:** _____

Information to be released by: _____

Information to be released to: _____

Information to be released: _____
(MUST BE SPECIFIED)

Purpose of release: _____

_____

I understand that I must voluntarily and knowingly sign this authorization before any information can be released, and that I may refuse to sign, but in that event the information cannot and will not be released. I also understand that service by the CHW is not conditioned on my signing this authorization.

This authorization will expire on (date): _____

I acknowledge that I have the right to revoke this authorization any time, and I understand that once the information is disclosed, it may no longer be protected by Federal privacy law. (You may revoke this authorization only in writing, in person or by certified mail to the Provider at the address above. The revocation will be effective only upon receipt, except to the extent Provider has acted on reliance on the authorization. Further information on the right to revoke may be provided from time to time in the Provider's Notice of Privacy Practices.)

Client or Authorized Signature _____ Date_____

If other than client, authority under which signature is made:

_____

INFORMED CONSENT FOR CASE MANAGEMENT

CLIENT ID:

Your health care case management is voluntary and confidential. No information will be given out about you without your written permission except as required by law or to provide services to you in compliance with federal privacy and security standards.

Please note:

1. We are mandatory reporter if Statutory Sexual Seduction (N.R.S. 200.364). This means that if you are 15 years of age or younger and are having sex with someone 18 years of age or older and you tell us, we must report it to law enforcement.

2. We are also mandatory reporters of Child Abuse and Neglect (N.R.S. 432B.220). This means that if we have cause to believe that there is any kind of abuse or neglect of a minor occurring, we must report it to law enforcement.

3. We are also mandatory reporters of lewdness (sex) with a child under the age of 14 (N.R.S. 201.230). This means that if we have a cause to believe that there are any kinds of vulgar or indecent activities occurring involving a child under the age of 14, we must report it to law enforcement.

I have the right to know everything about my care and am encouraged to ask questions.

I understand that in order for us to provide the services I request, I may need to disclose information of a personal nature and regarding my medical history. These may include:

- Date of birth
- Past/Current medical issues
- Contact information
- Tobacco/alcohol/substance use
- Medications
- Family dynamics

I have read (or have had read to me) the above information, understand this information, and give my permission for case management from the Community Health Advocate.

Signature: _____ Date: _____

Witness: _____ Date:_____

NEEDS ASSESSMENT

CLIENT ID:

A CHW provides a wide array of comprehensive services to assist clients with their healthcare needs. These services include: Behavioral Health; Social Services/Case Management; HIV, Hepatitis C, Diabetes, and Cancer Testing. To better assist you in accessing these services we respectfully request the following information:

First Name (first letter): _____

Birth Month: _____ _____

Last Name (first 3 letters): _____ _____ _____

Zip Code (last 3 digits): _____ _____ _____

Birth Year (last 2 digits): _____ _____

Client ID: _____

DO YOU NEED ASSISTANCE ACCESSING ANY OF THE FOLLOWING SERVICES?		
Service	YES	NO
1. Health insurance (such as Medicaid)	☐	☐
2. Social Security Disability	☐	☐
3. Food stamps	☐	☐
4. Welfare	☐	☐
5. Low-income housing	☐	☐
6. Employment training	☐	☐
7. Local food pantry	☐	☐
8. Affordable child care	☐	☐
9. Information about breastfeeding	☐	☐
10. Legal Advice	☐	☐
11. Emotional support	☐	☐
12. Translation/ Interpretation	☐	☐
13. Education/ School	☐	☐
14. Immigration law	☐	☐
15. Transportation	☐	☐
IN THE LAST 6 MONTHS, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?		
	YES	NO
16. Homelessness or couch surfing	☐	☐
17. Difficulty affording monthly rent and bills	☐	☐
18. Difficulty affording prescription medications and /or medical supplies	☐	☐
19. Difficulty affording a doctor's visit	☐	☐

20. Are you interested in an HIV or Hepatitis C test? ☐ Yes ☐ No
21. Are you interested in diabetes testing or cancer screening? ☐ Yes ☐ No
22. Are you interested in finding out if you qualify for WIC (the Women, Infants, and Children program) ☐ Yes ☐ No
23. Please indicate any other needs with which you would like assistance:

_____

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CLIENT MEDICAL HISTORY FORM

CLIENT ID:

CLIENT NAME:_____

Home Phone: _____Birth Date: _____
MONTH DAY YEAR

Spouse/Partner's Name: _____

Residence Street Address: _____
CITY, STATE, ZIP CODE

Cell Phone: _____Work Phone: _____

Marital Status:
☐ Married ☐ Divorced ☐ Single
☐ Separated ☐ Widowed ☐ Engaged
☐ Domestic Partner

Employment Status:
☐ Full Time ☐ Part Time ☐ Self-Employed
☐ Stay at Home/ Homemaker ☐ Retired ☐ Unemployed

Student Status:
☐ Full Time ☐ Part Time ☐ N/A

Whom may we thank for referring you?

Name:_____ Phone:_____

Address:_____

1. How would you rate your physical health?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Not sure

2. Are you now under the care of a physician? ☐ Yes ☐ No
If yes, who is your physician?_____
If no, date of last primary care provider visit: Month _____ Day _____ Year_____

3. How long has it been since you last visited a dentist or a dental clinic for any reason?
(Include visits to dental specialists, such as orthodontists)
☐ Within the past 6 months ☐ Within the past 2 years ☐ Six or more years ago
☐ Within the past year ☐ Within the past 5 years ☐ Have never visited a dentist

4. Height: _____ ft _____ inches Body Weight: _____lbs Abdominal Circumference: _____ inches (optional)

5. Have you had any serious illness or operation in the last 6 months? ☐ Yes ☐ No
If yes, what illness or operation?_____
Date: Month _____ Year _____ Location _____ Dr. _____

6. Have you been hospitalized in the past 6 months? ☐ Yes ☐ No
If yes, when and where? Date: Month _____ Year_____
Hospital: _____ City, State: _____

7. Please answer the following:

	Arthritis		Asthma		Cancer	
	YES	NO	YES	NO	YES	NO
Has a doctor or health professional ever told you that you have — ?						
(ASK IF YES ONLY)						
Are you currently seeing a provider for it?						
Have you had any hospitalizations for it in the past 6 months?						
Are you taking any medications for it?						
In the past 30 days, how many days have you missed work due to this disease?	____days N/A		____days N/A		____days N/A	
In the past 30 days, how many days have you taken your medication for this disease as prescribed by your doctor?	____days N/A		____days N/A		____days N/A	

	Pre-diabetes		Diabetes		Stroke	
	YES	NO	YES	NO	YES	NO
Has a doctor or health professional ever told you that you have — ?						
(ASK IF YES ONLY)						
Are you currently seeing a provider for it?						
Have you had any hospitalizations for it in the past 6 months?						
Are you taking any medications for it?						
In the past 30 days, how many days have you missed work due to this disease?	____days N/A		____days N/A		____days N/A	
In the past 30 days, how many days have you taken your medication for this disease as prescribed by your doctor?	____days N/A		____days N/A		____days N/A	

	Chronic Obstructive Pulmonary Disease (COPD)		High Blood Pressure or Hypertension		High Cholesterol	
	YES	NO	YES	NO	YES	NO
Has a doctor or health professional ever told you that you have — ?						
(ASK IF YES ONLY)						
Are you currently seeing a provider for it?						
Have you had any hospitalizations for it in the past 6 months?						
Are you taking any medications for it?						
In the past 30 days, how many days have you missed work due to this disease?	____days N/A		____days N/A		____days N/A	
In the past 30 days, how many days have you taken your medication for this disease as prescribed by your doctor?	____days N/A		____days N/A		____days N/A	

Notes on medications for any of these conditions:

_____

_____

_____

_____

8. Did you ever breastfeed or pump breast milk to feed your new baby after delivery, even for a short period of time?

☐ Yes ☐ No ☐ Not applicable

9. How would you rate your mental health?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Not sure

10. In the past **6 months,** how often did you feel any of the following:

Indicator	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Feel Depressed					
Feel Anxiety					
Experience Suicidal Feelings					
Experience Feelings of Isolation					

11. During the last **30 days,** how often did you feel any of the following?

Indicator	None of the time	A little of the time	Some of the time	Most of the time	All of the time
So sad that nothing could cheer you up					
Nervous					
Restless or fidgety					
Hopeless					
Worthless					
Everything was a struggle					

Comments:

_____

_____

_____

_____

_____

Physical Activity

1. During the past week, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?

☐ - Yes ☐ - No ☐ - Don't know/not sure

2. How many times per week did you take part in these activities during the past month? _____ time(s)

3. And when you took part in these activities, for how many minutes did you usually keep at it? _____ minutes

Nutrition

1. During the past month, not counting juice, how many times per week did you eat fruit? Count fresh, frozen or canned fruit. _____ time(s) per week

2. During the past month, how many times per week did you eat dark green vegetables, for example broccoli or dark leafy greens including romaine, chard, collard greens or spinach? _____ time(s) per week

3. During the past month, how many times per week did you eat orange colored vegetables such as sweet potatoes, pumpkin, winter squash or carrots? _____ time(s) per week

4. Not counting what you just told me about, during the past month, about how many times per week did you eat OTHER vegetables? Examples of other vegetables include tomatoes, tomato juice or V-8 juice, corn, eggplant, peas, lettuce, cabbage and white potatoes that are not fried such as baked or mashed potatoes. _____ time(s) per week

Tobacco Use

1. Do you currently use tobacco products such as cigarettes/cigars, e-cigarettes, chewing tobacco or hookah?

☐ - Every day ☐ - Some days ☐ - Not at all

2. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?

☐ - Yes ☐ - No

3. During the past week, on how many days did you breathe the smoke at your workplace or home from someone other than you who was smoking tobacco? _____ day(s) in past week

Alcohol Use

1. <u>During the past 30 days, how many days</u> did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor? _____ day(s) in past 30 days

2. One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average? _____ drink(s)

3. How many days in the past 30 days did you have 5 or more alcoholic beverages in 2 hours? _____ day(s) in past 30 days

Self-Efficacy Scale for Managing Chronic Disease

We would like to know *how confident* you are in doing certain activities. For each of the following questions, please choose the number that corresponds to your confidence that you can do the tasks regularly at the present time.

☐ Not applicable, have not been diagnosed with a chronic disease

1. How confident are you that you can keep the fatigue caused by your disease from interfering with the things you want to do?

_____ Not applicable (no fatigue is present)

2. How confident are you that you can keep the physical discomfort or pain of your disease from interfering with the things you want to do?

_____ Not applicable (no physical discomfort or pain is present)

3. How confident are you that you can keep the emotional distress caused by your disease from interfering with the things you want to do?

_____ Not applicable (no emotional distress is present)

4. How confident are you that you can keep any other symptoms or health problems you have from interfering with the things you want to do?

5. How confident are you that you can do the different tasks and activities needed to manage your health condition so as to reduce your need to see a doctor?

6. How confident are you that you can do things other than just taking medication to reduce how much your illness affects your everyday life?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or client's) health. It is my responsibility to inform my community health worker of any changes in medical status.

_____ _____

Signature Of Client, Parent, Or Guardian Date

PERSONAL WELLNESS PLAN - WORKSHEET

CLIENT ID:

People who are successful at making lifestyle changes take time to write out specific goals and a plan of action. Use this work sheet to write out your goals and action plans. Review the various area of your health. Decide in which areas you would like to make improvement. List your present situation and specify your goals (what you want to accomplish) in measurable terms. Keep track of your progress. Review your goals regularly. Get help from others as needed.

Personal wellness plan for: _____ Start date:_____

Weight Goal

Present Weight: _____ Goal Weight in 6 months: _____

Action plans:

_____

_____

Blood Pressure (BP)

Present BP: _____ Goal BP in 6 months:_____

Action plans:

_____

_____

Blood Cholesterol

Present:

Total cholesterol level:_____

HDL cholesterol level: _____

Goals:

Total cholesterol level:_____

HDL cholesterol level: _____

Action plans:

_____

_____

Healthy Eating

Specific things I want to do to improve my eating habits.

Action plans:

_____

_____

Physcial Activity

Number of days per week I currently get 30+ min of physical activity_____

Goals:

Active 30+ min _____ days per week Kinds of activities:_____

Action plans:

_____

_____

Stress and Coping

Ways I can improve mental/emotional health and coping skills such as daily relaxation, recreation, hobbies, social interaction, and avoid habits that waste productive living.

Action plans:

_____

_____

_____

Preventive Exams

Health tests and exams I want to do to keep current in my preventive exams:

Action plans:

_____

_____

_____

Addictive Behaviors

Habits I would like to change that seem to control me such as smoking, alcohol, drugs, gambling, binge eating, excessive work that damages my health and family life, or excessive TV viewing.

Action plans:

_____

_____

_____

Spiritual Health

Values, virtues, or service to others I would like to incorporate into my life that would provide meaning, purpose, peace, and enrichment to my life and to others.

Action plans:

_____

_____

_____

Other Changes

_____

_____

_____

Commitment

I choose to implement these wellness goals to the best of my ability.

_____ _____

Your Signature Date

_____ _____

CHW's Signature Date

CLIENT PROGRESS NOTE

CLIENT ID:

Client Name: _____ **Date:** _____

Reason for Meeting

Client reports:

_____

_____

_____

Other Symptoms: _____

Current Medications: _____

Onset of New Disease/s: _____

Visual Observations : _____

Weight: _____ Height: _____ BMI: _____

Assessment (Goals)

Short-term Goal: _____

Long-term Goal: _____

Plan (Future treatment)

Referrals Given: _____

Education Provided: _____

Suggested Follow-up: _____

Comments:

_____

_____

_____

CHW Signature: _____ Date _____

CHW Name (Print): _____ Date _____