Ubuntu Education Fund Annual Behavioral Health Screening

Surname: Name: Case #: Person Administering: Date: Age: ○F ○M

Occupation: Child Student Part Time Work Full Time Work List Work Details:

Others living in your home (name, age, and relationship):

How would you describe your general health?

Excellent Very Good Good Fair Poor

On average, how many **days** per week do you do moderate to strenuous exercise, like a brisk walk or jog?

0 1 2 3 4 5 6 7 Don't know

On average, how many **minutes** do you exercise at this level each day? _____

Do you eat fruits and vegetables every day? Yes No

Do you have any questions or concerns about your eating habits? Yes No

Do you always use your seat belt when in a car? Yes No

Do you ever drive under the influence of alcohol or drugs, or ride with a driver who is? Yes No

Do you or any of your friends have access to guns? Yes No

If yes, are they stored unloaded and locked? Yes No Don't know

Have you ever been a victim of threats-physical hurting, or forced sexual contact? Yes No

Comments:

During the past year, have you had any major changes in your life, good or bad? Yes No

If **YES**, please explain:

Have you ever had TB? Yes No

If **YES**, When?

Did you complete treatment? Yes No Doesn't apply to me

If **NO**, why not?

Has anyone in your family had TB? Yes No

If **YES**, Who and when?

Did they complete treatment? Yes No Doesn't apply to me

Have you ever been in jail? Yes No

Has anyone in your family ever been in jail? Yes No

Over the last 2 weeks, how often have you been bothered by little or no interest or pleasure in doing things?

(0) Not at all (1) Several days (2) More than half the days (3) Most days

Over the last 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?

(0) Not at all (1) Several days (2) More than half the days (3) Most days **Total Score:**

How often did you have one drink containing alcohol in the last year?

(0) Never (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week

How many drinks containing alcohol did you have on a typical day when you were drinking in the last year?

(0) I don't drink alcohol (1) 1 or 2 (2) 3 or 4 (3) 5 or 6 (4) 7 to 9 (5) 10 or more

How often did you have 6 drinks or more on one occasion in the last year?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

Score of 3 or more for women and 4 or more for men requires intervention **Total Score:**

In the last 12 months, have you used drugs other than for medical reasons? Yes No

Have you ever used tobacco? Yes No If **YES**, please answer the questions below:

Have you smoked 100 cigarettes or more in your lifetime? Yes No

Have you smoked at least part of a cigarette in the last month? Yes No

In the past month have you used any other kind of tobacco including cigars and smokeless tobacco (such as chewing tobacco, snuff, or pouches) Yes No

If you quit using tobacco, what was your quit date? _____

For Women Only

Was your first time having sexual intercourse more than 3 years ago? Yes No Doesn't apply to me

If you have sex with a male partner, do either of you use protection from pregnancy? Yes No Doesn't apply to me

If **YES**, what kind of protection:

Condoms Birth control pills IUD Depo-Provera Surgical method Tubal ligation Partner had a vasectomy

Other: _____

Do you plan to get pregnant within the next year? Yes No

For women who are still menstruating

When was your last period (date):

Had hysterectomy Menopause On contraception that prevents periods

Please describe your periods:

Regular Irregular Heavy Painful Absent Doesn't apply to me.

Does your period ever last longer than 5 days? Yes No

Is urination or leaking urine a problem for you? Yes No

For women who are pregnant or might become pregnant

Are you taking a daily supplement that has folate (folic acid)? Yes No

For women after menopause

Are you taking a daily supplement that has both vitamin D and calcium? Yes No

Have you had any bleeding since you stopped having periods? Yes No

Do you have pain with intercourse? Yes No

Notes:

For 15 and under only

Do you have any concerns, questions, or problems that you would like to discuss today?

What changes or challenges have there been at home since last year?

Do you have any special health care needs? Yes No Not sure, describe:

How many hours per day do you watch TV, play video games, and use the computer (not for schoolwork)?

We are interested in answering your questions. Please circle the topics you would like to discuss the most today.

Your Growing and Changing Body	How your body is changing Teeth Appearance or body image How you feel about yourself Healthy eating Good ways to keep active Protecting your ears from loud noise
School and Friends	Your relationship with your family Your friends Girlfriend or boyfriend How you are doing in school Organizing your time to get things done Plans after high school
How You Are Feeling	Dealing with stress Keeping under control Sexuality Feeling sad Feeling anxious Feeling irritable Keeping a positive attitude
Healthy Behavior Choices	Pregnancy Sexually transmitted infections (STIs) Smoking cigarettes Drinking alcohol Using drugs How to avoid risky situations Decisions about sex, alcohol, and drugs How to support friends who don't use alcohol and drugs How to follow through with decisions you have made about sex, alcohol, and drugs
Violence and Injuries	Car safety Using a helmet Driving rules for new teen drivers Gun safety Dating violence or abuse Bullying or trouble with other kids Keeping yourself and your friends safe in risky situations

Check off all the items that you feel are true for you.

- ☐ I engage in behavior that supports a healthy lifestyle, such as eating healthy foods, being active, and keeping myself safe.
- ☐ I feel I have at least one responsible adult in my life who cares about me and who I can go to if I need help.
- ☐ I feel like I have at least one friend or a group of friends with whom I am comfortable.
- ☐ I help others on my own or by working with a group in school, a faith-based organization, or the community.
- ☐ I am able to bounce back from life's disappointments.
- ☐ I have a sense of hopefulness and self-confidence.
- ☐ I have become more independent and made more of my own decisions as I have become older.
- ☐ I feel that I am particularly good at doing a certain thing like math, soccer, theater, cooking, or hunting. Describe:

Tell me about the people /groups that support you-making you feel comfortable, happy, and safe:
(Notes: Use children, parents, relatives, neighbors, friends, church and other groups to engage)

ASSESSMENT

Use age-appropriate language during the assessment and sit at the child's level. Allow the parent or guardian to sit with the child if appropriate. You may need to ask the smaller child to draw themselves and their family to show whether they feel as though they belong, and are as important as everyone else.

For small children:

Is there a constant caring adult who cares for the child? Yes No

If not, who cares for the child?

Where does the child live?

Ask the child:

Who do you love?

Who do you go to when you are sad?

What makes you happy?

Who makes you feel special or happy?

What do you like to do?

For older children and adolescents:

Do you have someone special who loves you?

Do you have someone special you love?

Who do you go to when you are happy?

Who do you speak to when you are sad or angry?

Tell me about yourself – what do you like about yourself? What can you do well?

Do you have a special friend/friends?

What would you like to do in the future?

If you could be or do anything, what would that be?

HIV ASSESSMENT

Are you sexually active? Yes No

Do you know your HIV status? No Yes Positive Negative Date of Last Test

Have you had sex (intercourse or oral sex) with a man, woman, or both? Man Woman Both Never had sex

Have you ever been treated for a sexually transmitted infection? Yes No

Notes:

Do you trade sex for money or drugs, or have sex partners who do? Yes No

Notes:

Are any current sexual partners known to be HIV positive? Yes No

Have you had sex with a new partner(s) since your last visit? Yes No

If **YES**, did you use condoms? Always Sometimes Never Doesn't apply to me

Education of HIV Given No Yes If no, Why

Do you want to test for HIV today? No Yes

If no, why:

If yes, ensure referred and brought down and fast tracked for testing to priority level in triage sheet

After test, discussion with client took place? Yes No

Test Results:

Date of Test:

Cd4:

Initiated on Treatment

Papsmear Education Given? Yes No, If no why Papsmear referral done (fast track as well) Papsmear Results:

Comments:

Comments on refusal to test should be added here. If risky behavior, risk reduction counseling should be given

IF the client is HIV-infected and this is known, it is important to talk to them about disclosure and ensuring their sexual partners are safe. Please write disclosure notes and acceptance of status notes here: