

FATHER/OTHER ANNUAL ASSESSMENT

*HSID: _____ - _____ - ____ *Screening Date: ____ / ____ / _____

*Staff _____

*Assessment Year: Year 1 Year 2 Year 3 Year 4 Year 5

Core Data Questions

*Highest level of Education Completed?

- No formal schooling
- Less than 8th grade
- Less than high school diploma
- High School graduate
- GED completed
- Some college/formal training beyond high school
- Technical training/ trade school or certification
- Associate's degree
- College (Bachelor's degree)
- Graduate Degree
- Other
- Don't Know
- Declined to answer

*Currently a Student or in Training? Yes No

*Employment Status

- Full Time
- Part Time < 30 hours per week
- Not Employed

Current Income Information. (Only count income that supports the whole family)

*Total Household Income (yearly)

*Adults (18 yrs+): *Children (17 or younger): *Total in Household:

Income Category: will populate in system if total in household information is entered

- 50% and under
- 51% - 100%
- 100% - 133%

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- 134% - 200%
- 201% - 300%
- >300%
- Unknown

Income level: will populate in system if total in household information is entered

- < 100% FPL
- 100%-185% FPL
- >185% FPL
- Unknown

*Housing Status

- Not Homeless
- Homeless (Not on Data System: If this is selected, Homeless situation is required)
- Unknown/ Did not report

*Homeless Situation

- Homeless and sharing housing
- Homeless and living in emergency or transitional shelter
- Homeless with some other arrangement

_____End of Core Data Questions_____

Address Information

Any changes to the client contact information must be done on the Enter Edit form.

Current Address _____
City _____ State _____ County _____
ZipCode _____ Phone _____ None

Client Information

Client's First Name: _____ Client's Last Name: _____

Date of Birth: _____

Current Age: _____ *If <age 24, meets CSHCN criteria? Yes No

*Participation Status:

- Primary Adult associated with child
- Accompanying Other Primary, explain _____
- Other, explain _____

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First and Last Name of All Enrolled Children

(Required if Participation Status is Primary Adult Associated with Child)

Please list Youngest Child First

Child First Name _____	Child Last Name: _____	Child's DOB: _____
Child First Name _____	Child Last Name: _____	Child's DOB: _____
Child First Name _____	Child Last Name: _____	Child's DOB: _____
Child First Name _____	Child Last Name: _____	Child's DOB: _____
Child First Name _____	Child Last Name: _____	Child's DOB: _____

*Relationship to Child(ren) Father/Step Father Other, Specify _____

Food

*In the last 12 months, did you (or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?

Yes, How often did this happen?

Almost every month

Some months but not every month

In only 1 or 2 months

No

Refused

Do you receive a Bridge Card (food Stamps)? Yes No

Transportation

*Do you have access to reliable transportation? Yes No

If No, please check all concerns that apply

Potential Unavailability

Unreliable

Not affordable

*Needs transportation assistance

Yes No

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Housing

*How many times have you moved in the past 12 months? 0 1 2 3 4 or more

* Do you currently have any concerns or worries about you housing situation? Yes No

If Yes what are your concerns or worries about your housing? (Check all that apply)

- No place to live, no regular nighttime residence
- Eviction or being forced to move out
- Affordability of current house or apartment
- Safety of house/apartment
- Strained relations with others in household
- Sanitation/Waste Removal
- House or apartment is too crowded
- Pest Control
- Safety of neighborhood
- Ease of access into home
- Code Violations
- Ventilation/Air Conditioning
- Lack of continuous functioning basic utility service (e.g. heat, electricity)

Telephone

How often do you have access to a telephone to make and receive calls?

- Always Sometimes Never

Physical Activity: BMI Calculation: Feet _____ Inches: _____ Weight: _____ BMI: _____

*In the past 30 days have you participated in any leisure time physical activity, such as walking, biking, swimming or other sports, etc.? Yes No

In an average week, how often do you participate in at least 30 minutes of physical activity?

- zero times once 2-3 times 4 times 5 or more

Oral Health

How long has it been since you had a dental exam and cleaning?

- Within the past year
- Within the past 2 years
- Within the past 5 years
- More than 5 years
- Don't know/not sure
- Never

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Medical

* Have you had an annual checkup visit to your primary care provider in the last 12 months?

Yes No

Vitals	Values	Results	Follow Up: Action taken
Blood Pressure (BP)		<input type="checkbox"/> WNL <input type="checkbox"/> Outside NL	
Temp		<input type="checkbox"/> WNL <input type="checkbox"/> Outside NL	
Pulse		<input type="checkbox"/> WNL <input type="checkbox"/> Outside NL	
Respiration		<input type="checkbox"/> WNL <input type="checkbox"/> Outside NL	
Other, Specify _____		<input type="checkbox"/> WNL <input type="checkbox"/> Outside NL	

Medical Conditions	Have been treated for or told that you have	Date of last visit to health care provider about this condition	Follow up needed? Y/N
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Group B Strep or Bacterial Vaginosis	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Recurring Vaginal Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sexually transmitted infection:	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

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High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes: Non-insulin dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Insulin dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Gestational (if hx of GDM ask about BS screen)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		
Family Hx Breast Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Hx of Other Cancer:	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Fecal Occult blood test (FOBT)/colon cancer screening	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Oral Health Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Illness: depression, bipolar, other	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Other: Specify	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Smoking:

*Do you currently smoke cigarettes? Yes No Refused

About how many do you smoke per day? _____

Have you cut down in the past year? Yes No Refused

Are you seriously considering quitting? Yes No Refused

Substance Use

*Are you currently in treatment for alcohol, drug, or substance use? Yes No Refused

Alcohol Use (AUDIT)

One drink = 12 oz./1 can of Beer, 5 oz. wine, 1.5 oz. liquor (one shot)

*Women: How many times in the past year have you had 4 or more drinks in a day?

*Men: How many times in the past year have you had 5 or more drinks in a day?

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None 1 or more Refused

If 1 or more, AUDIT is Required **AUDIT WILL BE REQUIRED IF 1 OR MORE IS SELECTED**

AUDIT (Alcohol Use Disorder Identification Test)

***1. How often do you have a drink containing alcohol?**

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

***2. How many drinks containing alcohol do you have on a typical day when you are drinking?**

- (0) 1-2
- (1) 3 or 4
- (2) 5 or 6
- (3) 7-9
- (4) 10 or more

***3. How often do you have six or more drinks in one occasion?**

- (0) Never
- (1) Less than Monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

***4. How often during the last year have you found that you were unable to stop drinking once you started?**

- (0) Never
- (1) Less than Monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

***5. How often during the last year have you failed to do what was normally expected of you because of drinking?**

- (0) Never
- (1) Less than Monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

***6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?**

- (0) Never
- (1) Less than Monthly
- (2) Monthly

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- (3) Weekly
- (4) Daily or almost daily

***7. How often during the last year have you felt guilt or remorse after drinking?**

- (0) Never
- (1) Less than Monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

***8. How often during the last year have you been unable to remember what happened the night before because of drinking?**

- (0) Never
- (1) Less than Monthly
- (2) Monthly
- (3) Weekly
- (4) Daily or almost daily

***9. Have you or someone else been injured as the result of your drinking?**

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year

***10. Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you quit?**

- (0) No
- (2) Yes, but not in the last year
- (4) Yes, during the last year

Total AUDIT Score: _____(system generated)

_____ End of Audit Screening _____

Drug Use:

Illicit drugs include Methamphetamines (speed, crystal), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium, Xanax), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

***In the past year have you used illicit drugs?**

- Yes No Refused

If yes, proceed to DAST

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*In the past year have you used marijuana?

Yes No Refused

If yes, proceed to DAST

*In the past year have you used prescription medication for non-medical reasons?

Yes No Refused

If yes, proceed to DAST

DAST WILL BE REQUIRED IF ANY OF THE ABOVE 3 QUESTIONS ARE ANSWERED YES

DAST 10

*1. Have you used drugs other than those required for medical reasons?

(1)Yes

(0)No

*2. Do you abuse more than one drug at a time?

(1)Yes

(0)No

*3. Are you always able to stop using drugs when you want to?

(1)Yes

(0)No

*4. Have you ever had blackouts or flashbacks as a result of drug use?

(1)Yes

(0)No

*5. Do you ever feel bad or guilty about your drug use?

(1)Yes

(0)No

*6. Does your spouse (or parents) ever complain about your involvement with drugs?

(1)Yes

(0)No

*7. Have you neglected your family because of your use of drugs?

(1)Yes

(0)No

*8. Have you engaged in illegal activities in order to obtain drugs?

(1)Yes

(0)No

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***9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?**

- (1) Yes
- (0) No

***10. Have you had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?**

- (1) Yes
- (0) No

TOTAL DAST SCORE _____ (system generated)

_____ End of DAST _____

DEPRESSION (PHQ9)

*PHQ9 Screening: Yes Not completed, Specify _____

If Yes, PHQ-9 Questionnaire is required. (Not on the Database)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last two weeks, how often have you been bothered by any of the following problems?

***1. Little interest or pleasure in doing things**

- (0) Not at all
- (1) Several days
- (2) More than half the days
- (3) Nearly every day

***2. Feeling down, depressed, or hopeless**

- (0) Not at all
- (1) Several days
- (2) More than half the days
- (3) Nearly every day

***3. Trouble falling or staying asleep, or sleeping too much**

- (0) Not at all
- (1) Several days
- (2) More than half the days
- (3) Nearly every day

***4. Feeling tired or having little energy**

- (0) Not at all
- (1) Several days
- (2) More than half the days
- (3) Nearly every day

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***5. Poor appetite or overeating**

- (0) Not at all
- (1) Several days
- (2) More than half the days
- (3) Nearly every day

***6. Feeling bad about yourself or that you are a failure or have let yourself or your family down**

- (0) Not at all
- (1) Several days
- (2) More than half the days
- (3) Nearly every day

***7. Trouble concentrating on things, such as reading the newspaper or watching television**

- (0) Not at all
- (1) Several days
- (2) More than half the days
- (3) Nearly every day

***8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual**

- (0) Not at all
- (1) Several days
- (2) More than half the days
- (3) Nearly every day

***9. Thoughts that you would be better off dead, or of hurting yourself**

- (0) Not at all
- (1) Several days
- (2) More than half the days
- (3) Nearly every day

***10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

Total PHQ9 Score _____(system generated)

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IF PHQ9 is completed the following question is required.

*** Staff: Please indicate which response best reflects the need for referral and/or follow-up services related to possible depression.**

- Participants total score was less than 10 and so did not indicate a need for referral
- Participants total score of 10 or more indicates that additional screening and referral is needed, and referral was provided
- Participants total score of 10 or more indicates that additional screening and referral is needed, but referral was not provided because client is already receiving services for possible depression
- Participant's total score of 10 or more indicates that additional screening and referral is needed, but referral was not provided because client declined referral.

Stress (Perceived Stress Scale)

*** In the last month, how often have you felt that you were unable to control the important things in your life?**

- Never (0)
- Almost Never (1)
- Sometimes (2)
- Fairly Often (3)
- Very Often (4)

*** In the last month, how often have you felt confident about your ability to handle your personal problems?**

- Never (4)
- Almost Never (3)
- Sometimes (2)
- Fairly Often (1)
- Very Often (0)

*** In the last month, how often have you felt that things were going your way?**

- Never (4)
- Almost Never (3)
- Sometimes (2)
- Fairly Often (1)

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Very Often (0)

*** In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?**

Never (0)

Almost Never (1)

Sometimes (2)

Fairly Often (3)

Very Often (4)

Higher Score, Higher the stress

Total Perceived Stress Score _____(system generated)

Abuse/ Violence:

Are you in a relationship now? Yes No Refused

Do you feel safe in your present relationship? Yes No Refused

***Have you ever been involved with Children's Protective Services with any of your children?**

Yes No Refused

***During the past 12 months has anyone....**

***a.Threatened you or made you feel unsafe in some way**

Current of former Intimate Partner

Other Family Member

Someone else

No-One

Declined to answer

***b.Made you feel frightened for your safety or your family's safety because of their anger or threats?**

Current of former Intimate Partner

Other Family Member

Someone else

No-One

Declined to answer

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*c. Tried to control your daily activities, for example, control who you could talk to for where you could go?

- Current of former Intimate Partner
- Other Family Member
- Someone else
- No-One
- Declined to answer

*d. Pushed, hit, slapped, kicked, choked, or physically hurt you in any other way?

- Current of former Intimate Partner
- Other Family Member
- Someone else
- No-One
- Declined to answer

*e. Forced you to take part in touching or any sexual activity when you didn't want to ?

- Current of former Intimate Partner
- Other Family Member
- Someone else
- No-One
- Declined to answer

*Staff- Indicate IPV screening status below

- Screening completed (all questions answered)
- Screening not completed due to:
 - Presence of partner
 - Presence of family member or friend
 - Participant declined to answer one or more questions
 - Other reason. Please Specify _____

Protective Factors Survey

Yes Not completed

FFR

SS:

CS:

NA.

CDKP

Total:

1. In my family, we talk about problems.

- (1) Never
- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently
- (6) Very Frequently
- (7) Always

2. When we argue, my family listens to “both sides of the story”.

- (1) Never
- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently
- (6) Very Frequently
- (7) Always

3. In my family, we take time to listen to each other.

- (1) Never
- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently
- (6) Very Frequently
- (7) Always

4. My family pulls together when things are stressful.

- (1) Never
- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently
- (6) Very Frequently
- (7) Always

5. My family is able to solve our problems.

- (1) Never
- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently
- (6) Very Frequently
- (7) Always

6. I have others who will listen when I need to talk about my problems.

- (1) Never

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- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently
- (6) Very Frequently
- (7) Always

7. When I am lonely, there are several people I can talk to.

- (1) Never
- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently
- (6) Very Frequently
- (7) Always

8. I would have no idea where to turn if my family needed food or housing.

- (1) Never
- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently
- (6) Very Frequently
- (7) Always

9. I wouldn't know where to go for help if I had trouble making ends meet.

- (1) Never
- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently
- (6) Very Frequently
- (7) Always

10. If there is a crisis, I have others I can talk to.

- (1) Never
- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently
- (6) Very Frequently
- (7) Always

11. If I needed help finding a job, I wouldn't know where to go for help.

- (1) Never
- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently

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(6) Very Frequently

(7) Always

12. There are many times when I don't know what to do as a parent.

(1) Never

(2) Very Rarely

(3) Rarely

(4) About half the time

(5) Frequently

(6) Very Frequently

(7) Always

13. I know how to help my child learn.

(1) Never

(2) Very Rarely

(3) Rarely

(4) About half the time

(5) Frequently

(6) Very Frequently

(7) Always

14. My child misbehaves just to upset me.

(1) Never

(2) Very Rarely

(3) Rarely

(4) About half the time

(5) Frequently

(6) Very Frequently

(7) Always

15. I praise my child when he/she behaves well.

(1) Never

(2) Very Rarely

(3) Rarely

(4) About half the time

(5) Frequently

(6) Very Frequently

(7) Always

16. When I discipline my child, I lose control.

(1) Never

(2) Very Rarely

(3) Rarely

(4) About half the time

(5) Frequently

(6) Very Frequently

(7) Always

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17. I am happy being with my child.

- (1) Never
- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently
- (6) Very Frequently

18. My child and I are very close to each other.

- (1) Never
- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently
- (6) Very Frequently
- (7) Always

19. I am able to soothe my child when he/she is upset.

- (1) Never
- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently
- (6) Very Frequently
- (7) Always

20. I spend time with my child doing what he/she likes to do.

- (1) Never
- (2) Very Rarely
- (3) Rarely
- (4) About half the time
- (5) Frequently
- (6) Very Frequently
- (7) Always

Notes: