Level I
Individuals/Families

The Community Health Worker Evaluation Tool Kit

A Project of The University of Arizona
Rural Health Office and
College of Public Health

"First We Observe"
–CHW

Sponsored by
The Annie E. Casey Foundation

Level I
Individuals/Families

Tools under each level of the framework are listed in alphabetical order by agency. A double asterisk (**) indicates the tool is included in Level I of the Tool Kit. An asterisk (*) indicates the tool is included in a different section within the same level or in an alternate level of the Tool Kit. Please refer to indices of Levels II, III and IV.

1.0 Activities/Outputs

1.1 Community health worker interactions with clients and families

Client Registration and Needs Assessment Form**	Arizona Department of Health Services
Prenatal Encounter Form**	Arizona Department of Health Services
Border Vision Fronteriza Follow-Up Form**	*Border Vision Fronteriza* Initiative
Juan Diego Community Center Activities Report**	*Centro Comunitario Juan Diego*
Contact Form*	*Juntos Contra el Cancer*
Assets/Needs Identification Form**	Latino Health Access
Community Survey**	Latino Health Access
Family Contact Form	Latino Health Access
Camp Health Aide Encounter Record	Migrant Health Promotion
Family Health Assessment Form	Migrant Health Promotion
Health Individual Encounter Record*	Migrant Health Promotion
Referral and Follow-Up Log*	Migrant Health Promotion
Community Health Worker Practices Log**	Opening Doors, New Mexico
Initial Data Record**	Opening Doors, Oregon
First Encounter Data Form	*Rio Colorado* Border Volunteer Project

1.2 Types and numbers of services provided

Client Registration and Needs Assessment Form*	Arizona Department of Health Services
Prenatal Encounter Form*	Arizona Department of Health Services
Family Contact Form	Latino Health Access
Glucose, Weight and Blood Pressure Record*	Latino Health Access
Family Health Assessment Form	Migrant Health Promotion
Health Individual Encounter Record**	Migrant Health Promotion
Referral and Follow-Up Log*	Migrant Health Promotion
First Encounter Data Form	*Rio Colorado* Border Volunteer Project

2.0 Outcomes

2.1 Access to and receipt of appropriate health care services

Client Registration and Needs Assessment Form*	Arizona Department of Health Services
Family Follow-Up Log Record**	Arizona Department of Health Services
California Family Contact Form*	*Border Vision Fronteriza* Initiative
Checklist for Complete Data Collection Forms	*Border Vision Fronteriza* Initiative
Family Contact Form	Latino Health Access

Camp Health Aide Encounter Record	Migrant Health Promotion
Camp Health Aide Program Cost-Effectiveness Analysis	Migrant Health Promotion
Referral and Follow-Up Log**	Migrant Health Promotion
Client Questionnaire*	Opening Doors, New Mexico
Community Health Worker Practices Log*	Opening Doors, New Mexico
First Encounter Data Form	Rio Colorado Border Volunteer Project
Follow-Up Form	Rio Colorado Border Volunteer Project

2.2 Social support

Family Follow-Up Log Record*	Arizona Department of Health Services
Community Health Survey	East Side Health Worker Partnership
Assets/Needs Identification Form*	Latino Health Access
Family Contact Form	Latino Health Access
Camp Health Aide Encounter Record	Migrant Health Promotion
Camp Health Aide Program Cost-Effectiveness Analysis	Migrant Health Promotion
Client Questionnaire*	Opening Doors, New Mexico
Initial Data Record*	Opening Doors, Oregon

2.3 Knowledge, attitudes, beliefs and risk and protective behaviors

In Home Pre-Presentation**	*Centro Comunitario Juan Diego*
Post-Presentation Form*	*Centro Comunitario Juan Diego*
Community Health Survey	East Side Health Worker Partnership
Promotor/a Evaluation*	*Juntos Contra el Cancer*
Community Survey*	Latino Health Access
Family Contact Form	Latino Health Access
Exit Form	Opening Doors, Oregon
Initial Data Record*	Opening Doors, Oregon
Follow-Up Form	Rio Colorado Border Volunteer Project

2.4 Client satisfaction

Community Health Advocate Survey**	Center for Healthy Communities
Community Health Worker Satisfaction Questionnaire**	The Johns Hopkins University, School of Hygiene and Public Health
Program Evaluation**	Healthier Communities Department of Spectrum Health
Promotor/a Evaluation**	*Juntos Contra el Cancer*
Community Survey*	Latino Health Access
Client Questionnaire**	Opening Doors, New Mexico

3.0 Impacts

3.1 Community participation

Post-Presentation Form**	*Centro Comunitario Juan Diego*
Exit Form	Opening Doors, Oregon

3.2 Quality of life

Community Health Survey	East Side Health Worker Partnership
Promotor/a Evaluation*	*Juntos Contra el Cancer*
Family Contact Form	Latino Health Access
Pre-Exam and Post-Exam**	Planned Parenthood of Los Angeles
Client Questionnaire*	Opening Doors, New Mexico

3.3 Health Status

Family Follow-Up Encounter Form**	Arizona Department of Health Services
Family Follow-Up Log Record*	Arizona Department of Health Services
Prenatal Outcome Form**	Arizona Department of Health Services
California Family Contact Form*	*Border Vision Fronteriza* Initiative
Checklist for Complete Data Collection Forms	*Border Vision Fronteriza* Initiative
Health-Realted Quality Of life**	Health Care and Aging Studies Branch CDC
MOS 36-Item Short Form Health Survey**	The Health Assessment Lab
Promotor/a Evaluation*	*Juntos Contra el Cancer*
Team Plan Form**	Latino Health Access
Glucose, Weight and Blood Pressure Record**	Latino Health Access
Diabetes Retinopathy Evaluation Form**	Latino Health Access
Pre-Exam and Post-Exam*	Planned Parenthood of Los Angeles
Exit Form	Opening Doors, Oregon
Follow-Up Form	Rio Colorado Border Volunteer Project

Arizona Department of Health Services
Health Start Program

I.1.1

Client Registration Form
Client Needs Assessment

ID Number _____ Lay Health Worker _____ Today's Date _____/_____/_____

_____ _____ _____ _____/_____/_____
Mother's Last Name First Name Maiden Name Date of Birth

RISK ASSESSMENT:	True	History	Unknown	Tally Risk
Heart Problems	❑	❑	❑	❍
Diabetes/Gestational diabetes	❑	❑	❑	❍
High Blood pressure	❑	❑	❑	❍
Sexually transmitted diseases	❑	❑	❑	❍
Multiple pregnancy	❑	❑	❑	❍
Mother smoked/suspected	❑	❑	❑	❍
Alcohol use/suspected	❑	❑	❑	❍
Drug use (incl. prescription)/suspected	❑	❑	❑	❍
Mother uses smokeless tobacco	❑	❑	❑	❍
Does not use seat belts	❑	❑	❑	❍
Other household members smokes	❑	❑	❑	❍
Other household member abuses alcohol	❑	❑	❑	❍
Homeless	❑	❑	❑	❍
Migrant	❑	❑	❑	❍
Does not read or speak English	❑	❑	❑	❍
Not enough money to meet basic needs	❑	❑	❑	❍
No plan to pay for delivery	❑	❑	❑	❍
Has insufficient network	❑	❑	❑	❍
Is new to the community	❑	❑	❑	❍
Is geographically isolated	❑	❑	❑	❍
Has unsupportive or no family	❑	❑	❑	❍
Other children not immunized	❑	❑	❑	❍
Other children without medical home	❑	❑	❑	❍
Lack of knowledge or fear of pregnancy	❑	❑	❑	❍
Age (under 19 or over 35)	❑	❑	❑	❍
Other children under 2	❑	❑	❑	❍
Is not in prenatal care	❑	❑	❑	❍
Has no transportation	❑	❑	❑	❍
Is victim of family violence	❑	❑	❑	❍
Other	❑	❑	❑	❍

PREGNANCY HISTORY:

Number of pregnancies (including this one) _____
Number of live births _____

	Yes	No	Unknown	Tally
First Pregnancy	❑	❑	❑	❍
Low Birth Weight	❑	❑	❑	❍
Stillbirths	❑	❑	❑	❍
Miscarriage/Abortion	❑	❑	❑	❍
Premature labor/Birth	❑	❑	❑	❍
Cesarean sections	❑	❑	❑	❍
Other	❑	❑	❑	❍

	Receiving	Waiting	Denied	Referred	Barriers
DCSE	❑	❑	❑	❑	_____
CPS	❑	❑	❑	❑	_____
AHCCCS	❑	❑	❑	❑	_____
Unemployment	❑	❑	❑	❑	_____
AFDC	❑	❑	❑	❑	_____
Food Stamps	❑	❑	❑	❑	_____
WIC	❑	❑	❑	❑	_____
CSFP	❑	❑	❑	❑	_____
Food Bank	❑	❑	❑	❑	_____
AzEIP	❑	❑	❑	❑	_____
SSA	❑	❑	❑	❑	_____
Other Prenatal Prgm	❑	❑	❑	❑	_____
Employment	❑	❑	❑	❑	_____
Transportation	❑	❑	❑	❑	_____
Child Care Services	❑	❑	❑	❑	_____
Early Childhood Ed	❑	❑	❑	❑	_____
Adult Ed	❑	❑	❑	❑	_____
Prenatal Classes	❑	❑	❑	❑	_____
Parenting Classes	❑	❑	❑	❑	_____
Breastfeeding Classes	❑	❑	❑	❑	_____
Other	❑	❑	❑	❑	_____

BARRIERS: 1= Not Available 2= Language 3= Transportation 4= Client Refusal

	Receiving	Waiting	Denied	Referred	Barriers
Referral to Community Resources:					
Prenatal Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Well Baby Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Primary Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Immunizations CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Family Planning CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Dental Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Nursing Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Mental Health Services CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Social Services CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Hearing/Vision CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Genetic Services CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____

Tally Total ☐

BARRIERS: 1= Not Available 2= Language 3= Transportation 4= Client Refusal

FATHER OF THE INDEX CHILD INFORMATION:
(Optional)

Name: _____

Date of Birth: _____/_____/_____

Race:

- ❑ White/Non-Hispanic
- ❑ Hispanic
- ❑ Black
- ❑ Native American
- ❑ Asian/Pacific Islander
- ❑ Unknown
- ❑ Other

Does he live in the home:	Yes ❑	No ❑
Is he employed:	Yes ❑	No ❑
Does he contribute....		
emotional support?	Yes ❑	No ❑
financial support?	Yes ❑	No ❑

Education: (Choose all that apply)

- ❑ High school graduate or equivalent
  - ❑ College 1-4 years
  - ❑ College 5+ years
  - ❑ Trade/Vocational School
- ❑ Did not graduate high school
  Last grade completed: _____
- ❑ Unknown
- ❑ Other

PROGRAM STATUS:

NOT PREGNANT:
- ❑ Family planning

PREGNANT:
- ❑ Not eligible
- ❑ Declined enrollment:
  - ❑ Informed Consent
  - ❑ Other prenatal Program
  - ❑ Other
- ❑ Enrolled
- ❑ Transfer

Arizona Department of Health Services
Health Start Program

I.1.1

Prenatal Encounter Form

ID Number _____ Lay Health Worker _____ Today's Date _____/_____/_____

Mother's Last Name	First Name	Maiden Name	Date of Birth
_____	_____	_____	_____

Dates of Attempted Visits
_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____

New Address: (if applicable) _____

Did your client have one or more prenatal visits since the last LHW visit?
❑ Yes # ____
❑ No

_____/_____/_____
Date of Next Prenatal Visit

❑ Length of Visit: _____ (in minutes)

❑ No Visit

PROGRAM STATUS:

CONTINUING

❑ Continuing Prenatal

CLOSED

❑ Lost to Follow-Up/Moved
❑ Referred to Other Program
❑ Client Withdrew from Program
❑ Pregnancy Losses
❑ Client Dropped from Program
❑ Transferred to Other Site

PLACE OF MEETING:

❑ Not Applicable
❑ Neighbor's Home
❑ Clinic
❑ Hospital
❑ Other _____
❑ Mother's Home
❑ Relative's Home
❑ Community Center
❑ School
❑ LHW's Home
❑ Program Office
❑ Social Event
❑ Telephone Visit

EDUCATION TOPICS DISCUSSED:

- ❑ Health Start program
- ❑ Women's Health
- ❑ Maternal High Risk Conditions
- ❑ Hearing/Vision Testing
- ❑ Smoking/Alcohol
- ❑ Child Nutrition/Diet
- ❑ Safety
- ❑ Immunizations
- ❑ Changes during Pregnancy
- ❑ Emotions/Feelings
- ❑ Unmet Needs
- ❑ Child High Risk Conditions
- ❑ Breastfeeding
- ❑ Abuse/Domestic Violence
- ❑ Early Childhood Education
- ❑ Prenatal Care
- ❑ Finances
- ❑ Educational Programs - Parent
- ❑ Labor/Delivery
- ❑ Maternal Diet
- ❑ Parenting Skills
- ❑ Family Planning
- ❑ Transportation
- ❑ Child's Health & Development
- ❑ Infant Care
- ❑ Changes after Pregnancy
- ❑ Other _____

TRANSPORTATION ASSISTANCE:

- ❑ Tokens/Passes
- ❑ Transportation Available
- ❑ Cab Arrangements
- ❑ None Needed
- ❑ Community Arrangements

REFERRALS TO COMMUNITY RESOURCES	Receiving	Waiting	Denied	Referred	Barriers
DCSE	❑	❑	❑	❑	_____
CPS	❑	❑	❑	❑	_____
AHCCCS	❑	❑	❑	❑	_____
Unemployment	❑	❑	❑	❑	_____
AFDC	❑	❑	❑	❑	_____
Food Stamps	❑	❑	❑	❑	_____
WIC	❑	❑	❑	❑	_____
CSFP	❑	❑	❑	❑	_____
Food Bank	❑	❑	❑	❑	_____
AzEIP	❑	❑	❑	❑	_____
SSA	❑	❑	❑	❑	_____
Other Prenatal Prgm	❑	❑	❑	❑	_____
Employment	❑	❑	❑	❑	_____
Transportation	❑	❑	❑	❑	_____
Child Care Services	❑	❑	❑	❑	_____
Early Childhood Ed	❑	❑	❑	❑	_____
Edult Ed	❑	❑	❑	❑	_____
Prenatal Classes	❑	❑	❑	❑	_____
Parenting Classes	❑	❑	❑	❑	_____
Breastfeeding Classes	❑	❑	❑	❑	_____
Other	❑	❑	❑	❑	_____

Prenatal Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Well Baby Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Primary Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Immunizations CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Family Planning CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Dental Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Nursing Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____

BARRIERS: 1= Not Available 2= Language 3= Transportation 4= Client Refusal 5= Other

Referral to Community Resources:	Receiving	Waiting	Denied	Referred	Barriers
Mental Health Services CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Social Services CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Hearing/Vision CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____
Genetic Services CHD CHC MSP IHS OTH	❑	❑	❑	❑	_____

BARRIERS: 1= Not Available 2= Language 3= Transportation 4= Client Refusal 5= Other

Did or does your client have any of the following danger signs? ❑ Yes ❑ No

If Yes, mark the signs and make appropriate referrals to health care provider:

❑ Bleeding ❑ Headaches ❑ Contractions
❑ Cramping ❑ Fever ❑ Burning wit Urination
❑ Blurred vision ❑ Swelling face/hands ❑ Vaginal discharge
❑ Other: _____

To whom did you refer your client? _____

Does your client breastfeed her baby? ❑ Yes ❑ No

Has a family planning goal been identified? ❑ Yes ❑ No

University of Arizona Rural Health Office
Border Vision Fronteriza Transition Phase 2

I.1.1

Medi-Cal/Healthy Families (HF) and Children's Health Services Follow-Up Form*

***Promotor/a* Code:** ___ ___ ___ ___ ___

Family Code:	Child's First and Last name/ Date of Birth:	Provider Referral Follow-Up Date:	Seen by Provider:	Reason(s) Not Seen[1]	Medi-Cal/HF Follow-Up Date:	Enrollment[3] Status (F1)	Reason(s)[2] Denied:	Enrollment Status (F2)	Reason(s)[2] Denied:
			Y N			E D P		E D	
			Y N			E D P		E D	
			Y N			E D P		E D	
			Y N			E D P		E D	
			Y N			E D P		E D	
			Y N			E D P		E D	
			Y N			E D P		E D	
			Y N			E D P		E D	
			Y N			E D P		E D	
			Y N			E D P		E D	
			Y N			E D P		E D	
			Y N			E D P		E D	

1 Reason not seen by provider: (1) Can't get appointment, (2) Financial, (3) No Transportarion, (4) Not friendly place, (5) Child got better, (6) No Provider available, (7) Other
2 Enrollment Status Key: F1=First follow-up F2=Second follow-up for those application that are pending in F1. **E=Enrolled D=Denied P=Pending**
3 Reason(s) denied: (1) Income too high, (2) Incomplete application, (3) Residency, (4) Not friendly place, (5) Did not apply, (6) Did not keep appointment, (7) Not transportation, (8) Other

* Form is available in spanish

Centro Comunitario Juan Diego
Chicago, IL

I.1.1

Juan Diego Community Center's Activities Report*

The neighborhood Health *Promotores/as* and volunteers from Juan Diego Community Center contributed hundreds of hours of service to the community of South Chicago during the year _____. The activities that appear in the yearly report are the fruit of many hours of service committed to the Mission of Juan Diego Community Center.

REPORTS ON PROGRAMS AND EVENTS (PLEASE DESCRIBE ACCORDING TO YOUR PROGRAM):

1. Food Pantry Program

2. Home Visiting Program "A Visit Counts"

3. Training Program for neighborhood Health *Promotores/as*

4. Education Program for the Prevention of HIV/AIDS

5. Mammogram Program

6. Education Program about Breast Cancer

7. Immunization Program

8. Community Organizing Programs (Examples: book clubs, court advocay)

** Form is available in Spanish*

9. The Study on Diabetes conducted by University of Illinois at Chicago

10. Children's Car Seat Program

11. Mental health Program at Bowen High School "Bringing Nobody but Yourself"

12. Summer Program for Children and Parents "A Day in the Sun"

13. English Program for neighborhood Health *Promotores/as*

14. After-school Tutoring Program "A Group of Friends"

15. After-school Program for Girls "Juan Diego's Junior Health *Promotoras/es*"

16. Community Gardening Program

17. The Faith Sharing Group

18. The Committee "Building on Solidarity"

19. Events on Immigration

20. Health Fairs

21. Special Events sponsored by Juan Diego Community Center

22. Other Community Organizations events where Juan Diego Community Center participated

23. Events as part of Coalition Pro.Me.Sa

DIRECT SERVICES

Juan Diego Community Center responds to hundreds of direct services request. Examples of requests are the following:

- Emergency food
- Clothing distribution
- Information about immigration
- Information about health services
- Referrals to other agencies
- Translation
- Information on jobs
- Information about housing

Latino Health Access
Conociendo Nuestra Comunidad
Family Visits

Assets/Needs Identification Form*

Please answer (Y) Yes or (N) No for every category under every family member.

	NEEDS					ASSETS				
Priority Areas	**Father**	**Mother**	**Children**	**Uncle/Aunt**	**Grandparents**	**Father**	**Mother**	**Children**	**Uncle/Aunt**	**Grandparents**
1. EDUCATION										
Read and write Spanish										
Speak English										
Children attend school										
Teens attend school										
Provide help with school homework assignments										
Participate in school-related activities										
2. HEALTH										
Have health insurance										
Have access to a community health clinic										
Visit doctors on the border										
Visit doctors in another country Do not visit the doctor										
3. ECONOMY										
Work 5 days or more										
Work less than 5 days										
Salary adequate to number of family members										
Food is available										
4. LEISURE										
Go to the park										
Play sports										
Other leisure activities										
Access to leisure activities plan										

* *Form is available in Spanish*

	NEEDS					ASSETS				
Priority Areas	**Father**	**Mother**	**Children**	**Uncle/Aunt**	**Grandparents**	**Father**	**Mother**	**Children**	**Uncle/Aunt**	**Grandparents**
5. SAFETY AT HOME										
◗ CPR and First Aid Training										
◗ Safety Plan										
◗ Violence is present										
◗ Child care										
6. NEIGHBORHOOD SAFETY										
◗ Identify gangs										
◗ Identify thefts										
◗ Identify child abuse										
◗ Identify alcoholics										
◗ Identify drug addicts										
◗ Have witnessed shootings										
◗ Family member killed due to street violence										
◗ Safety at railroad crossings										
7. COMMUNITY DEVELOPMENT										
◗ Participate in community committees										
◗ Attend youth groups										
◗ Identify community leader										
8. CULTURAL										
◗ Identify cultural events										
◗ Attend cultural events										
◗ Maintain cultural customs										

All (Y)'s are assets; all (N)'s are needs.

Latino Health Access

Community Survey*

SECTION I. FAMILY INFORMATION
(collect information for each individual family member)

Family Code: _____ **(Zip Code - Family ID)**

1. How many members of your family live here (including yourself)? ☐
2. How many women between the ages of 13 and 45 live here? ☐
3. How many men above the age of 18 live here? ☐
4. How many children below age 5 live here? ☐
5. What is your family's annual income? ☐

1. $ 0 - $4,999	7. $30,000 - $64,999	13.$60,000 - $64,000
2. $ 5,000 - $9,999	8. $35,000 - $39,999	14.$65,000 - $69,000
3. $10,000 - $14,999	9. $40,000 - $44,999	15.$70,000 - $74,999
4. $15,000 - $19,999	10.$45,000 - $49,999	16.$75,000 - $99,000
5. $20,000 - $24,999	11.$50,000 - $54,999	17. $100,000 or more
6. $25,000 - $29,999	12.$55,000 - $59,000	18. Don't know/no answer

Assign a code to each person (child or adult) interviewed for this survey

1=male
2=female

1 = Mexico
2 = USA
3 = El Salvador
4 = Guatemala
5 = Other

1 = no insurance
2 = Medi-Cal
3 = Emergency Medi-Cal
4 = Medicare
5 = MSI
6 = private insurance
7 = Healthy Families
8 = Other

1 = labor
2 = housewife
3 = servicel
4 = student
5 = agriculture
6 = professional
7 = doesn't work
8 = Other

1 = less than 9 yrs
2 = 9-12 yrs., no diploma
3 = high school graduate/GED
4 = SOME COLLEGE, NO DEGREE
5 = Associates degree
6 = Bachelor's degree
7 = Master's or Phd

Code	Gender	Age	Native Country	Years in the U.S.	Years in S.A.	Years at current address	Months at current address	Health Insurance	Occupation	Education	Alcohol Use	Tobacco Use

	1st Visit	2nd Visit	3a Visit
Time			
Date			

1 = does not drink
2 = drinks socially
3 = drinks everyday
4 = drinks on weekends

1 = smokes
2 = does not smoke

Interviewer (this section): _____

** Form is available in Spanish*

SECTION II. INFORMATION ON WOMEN

Family Code: _____ **Respondent's Code:** _____

1. How would you rate your health status?
[1] very healthy [3] fairly healthy [5] I don't know
[2] healthy [4] not healthy

2. Do you receive medical care?
[1] yes [2] no

3. Who provides medical services to you? (check all that apply)
[1] community clinic [3] private physician [5] I don't know
[2] hospital [4] other_____

4. What problems have prevented you from going to a doctor? (check all that apply)
[1] child care [3] no insurance [5] other _____
[2] transportation [4] no money

5. Are you currently married?
[1] yes
[2] Single
[3] Separated
[4] Divorced
[5] Widowed
[6] Other_____

6. Is your husband living with you?
[1] yes [2] no

7. Do you perform a breast self-exam on a monthly basis?
[1] yes [2] no [3] occasionally

8. Have you had a mammogram?
[1] yes, when did you have your last mammogram? ☐☐ month ☐☐ year
[2] no [3] I don't know **(Go to Question 10)**

9. What was the result of your mammogram?
[1] normal [3] I don't know [5] not applicable
[2] abnormal [4] I don't remember

10. Have you had a pap smear test in the last year?
[1] yes [2] no [3] I don't know **(Go to Question 12)**

11. What was the result of your pap smear test?
[1] normal [3] I don't know [5] not applicable
[2] abnormal [4] I don't remember

12. Are you or have you ever been pregnant?
[1] yes [2] no ***(skip to question 32 on next page)***

SECTION II. INFORMATION ON WOMEN (continued)

13. How old were you during your first pregnancy? ☐

14. How many pregnancies have you had? ☐

15. How many pregnancies have you had in the USA? ☐

16. In how many of these pregnancies did you obtain prenatal care? ☐

17. In what month of your most recent pregnancy did you seek prenatal care? ☐

18. How many spontaneous abortions have you had? ☐

19. How many still births have you had? ☐

20. How many children weighed <2,500 grams or <5.5 lbs? ☐ If not applicable, check here ☐

21. Are you presently pregnant?
☐ 1 yes ☐ 2 no ***(skip to question 24)***

22. How many months are you pregnant? ☐

23. Have you sought prenatal care during this pregnancy?
☐ 1 yes ☐ 2 no

24. In which month of your most recent pregnancy did you begin prenatal care? ☐

25. Why did you not seek prenatal care in your most recent pregnancy? (check all that apply)
☐ 1 don't have money ☐ 5 don't have anyone to take me
☐ 2 don't know where to go ☐ 6 don't know city
☐ 3 don't need it ☐ 7 I am undocumented
☐ 4 don't speak English ☐ 8 other _____

26. Where did you get prenatal care (in U.S)?
☐ 1 community clinic ☐ 3 private physician
☐ 2 hospital ☐ 4 other_____

27. Have you gone to pregnancy classes?
☐ 1 yes ☐ 2 no

28. Did you drink alcohol during your most recent pregnancy?
☐ 1 yes ☐ 2 no

29. Did you smoke during your most recent pregnancy?
☐ 1 yes ☐ 2 no

30. Did you consume drugs during your most recent pregnancy?
☐ 1 yes ☐ 2 no

SECTION II. INFORMATION ON WOMEN (continued)

31. Have you had any of the following complications during your most recent pregnancy?
(check all that apply)

- [1] high blood pressure
- [2] diabetes physician
- [3] miscarriage risk
- [4] multiple pregnancies
- [5] hemorrhage
- [6] urinary tract infection
- [7] anemia
- [8] premature birth
- [9] STD
- [10] RH factor
- [11] none of the above

32. Have you been sexually active (vaginal intercourse) for the past one year?

[1] yes [2] no

33. Are you using some type of birth control method?

- [1] the pil
- [2] condom
- [3] I.U.D.
- [4] diaphragm
- [5] vasectomy
- [6] Norplant
- [7] injection
- [8] abstinence
- [9] withdrawal
- [10] tubal litigation
- [11] rhythm
- [12] foam
- [13] other_____
- [14] don't use any

34. Where do you receive family planning services? (check all that apply)

- [1] County
- [2] community clinic
- [3] private physician
- [4] other_____
- [5] Other services but none of the above
- [6] I don't receive services

35. Who decides on family planning issues?

[1] you [2] your partner [3] both [4] not applicable

36. Have you ever been physically abused by your husband, partner, or father of your children?

[1] yes [2] no [3] no answer

Observations _____

Interviewer (this section): _____

SECTION III. INFORMATION ON CHILDREN

Family Code: _____ **Respondent's Code:** _____

1. How many children you care for are 5 years old or younger? ____

2. How many of these children (age 5 or under) were born in the USA? ____

3. How many of these children have experienced the following?
(write the number of children in the boxes. If unknown, leave blank)

a. born at home (US births only) ____
b. born with low birth weight (all births) ____
c. was not breast-fed (all births) ____
d. premature (all births) ____
e. complications during labor (all births) ____

4. How many of these children have any of the following? (check all that apply)

a. whooping cough ____
b. tetanus ____
c. diphtheria ____
d. polio ____
e. hepatitis ____
f. measles ____
g. tuberculosis ____
h. mumps ____
i. German Measles ____
j. chicken pox ____
l. I don't know (check box) ____

5. Does anyone in your family have (or has had) active TB?
[1] yes [ ] no [ ] I don't know

6. For the majority of the time, who takes care of the children?
[1] mother [2] father [3] mother & father [4] grandparents [5] aunts/uncles [6] minors under 15 [7] friends [8] child care ctr. _____ [9] stay home by themselves [10] other _____

7. Do you use a child safety seat in your car for your children?
[1] yes [2] no

8. How many children died before the age of 5? If not applicable, check here

9. Has any child died from drowning?
[1] yes [2] no [3] I don't know

10. How many children you care for are followed up in a Well Child Health Prog. (CHDP)? ____

11. How many of these children have a medical provider? ____

12. Do you consider the children five years of age and under to be healthy?
[1] yes [2] no [3] I don't know

13. Have you taken any of the children for medical care to places other than a clinic, a hospital or a doctor (e.g. a gift shop, an herb store, etc.)?
[1] yes [2] no [3] I don't remember

14. Do you give the children medicine (antibiotics, injections, etc.,) without going to a doctor?
(does not refer to over-the-counter medications such as aspirin, Tylonol, cough syrups, etc.)
[1] yes [2] no [3] I don't remember 4 I don't know

15. Do you take your children to Tijuana or other border towns in Mexico to receive medical care?
[1] yes [2] no [3] I don't know

SECTION IV. IMMUNIZATION INFORMATION

Family Code: ☐

1. Child's Mother's name _____ **Code (mother):** ☐

2. Child's name _____ **Code (child):** ☐

3. Child's Age ☐

4. Date of birth ☐☐ ☐☐ ☐☐
mo. day yr.

5. Is your child up to date with his or her immunization?
☐1 yes ☐2 no ☐3 I don't know

6. Why is your child not completely immunized? (if answer to question 5 is "no")
☐1 don't know where to go ☐3 don't have money ☐5 don't know about vaccination
☐2 unfamiliar with city ☐4 not interested ☐6 I don't know
7 other _____

7. In what country was your child immunized?
☐1 USA ☐3 Latin America ☐5 USA and another country
☐2 I do not remember ☐4 I don't know ☐6 not applicable

8. Do you have your child's immunization record?
☐1 yes ☐2 I can't find it ☐3 no ☐4 don't know

Question 9 to be answered by the public health nurse

9. Is the child up to date with immunizations for his or her age?
☐1 yes ☐2 no ☐3 could not verify

Signature _____

SECTION V. COMMUNITY PERCEPTIONS

Family Code: _____ **Respondent's Code:** _____

1. Sex [1] male [2] female

2. Age _____

3. What is your perception of the following problems in your community?

	no problem	slight problem	serious problem	I don't know
a. Consumption of drugs	[0]	[1]	[2]	[8]
b. Sale of drugs	[0]	[1]	[2]	[8]
b. Sale of drugs	[0]	[1]	[2]	[8]
b. Sale of drugs	[0]	[1]	[2]	[8]
b. Sale of drugs	[0]	[1]	[2]	[8]
b. Sale of drugs	[0]	[1]	[2]	[8]
b. Sale of drugs	[0]	[1]	[2]	[8]
b. Sale of drugs	[0]	[1]	[2]	[8]
b. Sale of drugs	[0]	[1]	[2]	[8]
b. Sale of drugs	[0]	[1]	[2]	[8]
c. Alcoholism	[0]	[1]	[2]	[8]
d. Drive-by shooting	[0]	[1]	[2]	[8]
e. Domestic violence	[0]	[1]	[2]	[8]
f. Teen pregnancies	[0]	[1]	[2]	[8]
g. Children out of school	[0]	[1]	[2]	[8]
h. Children alone at home	[0]	[1]	[2]	[8]
i. Loitering	[0]	[1]	[2]	[8]
j. Crime	[0]	[1]	[2]	[8]
k. Gangs	[0]	[1]	[2]	[8]
l. Graffiti	[0]	[1]	[2]	[8]
m. Firearms	[0]	[1]	[2]	[8]
n. Lack of cleanliness	[0]	[1]	[2]	[8]
o. other_____		[1]	[2]	
p. other_____		[1]	[2]	

4. When you call the police for assistance do they arrive fast enough?

[1] yes [3] I don't know
[2] no [4] not applicable

5. When there is an emergency in the community, do the fire department and ambulance arrive fast enough?

[1] yes [3] I don't know
[2] no [4] not applicable

SECTION V. COMMUNITY PERCEPTIONS (continued)

6. Do you go to the public parks in your neighborhood with your family?

[1] no [2] a few times a year
[3] 1 or 2 times a month [4] more than 2 times a month

Which parks?

_____

_____

7. Why don't you go to public parks? (check all that apply)

[1] I don't like them [4] they are unsafe [7] other_____
[2] they are dirty [5] I don't know where they are
[3] gangs [6] I don't have time [8] not applicable

8. Do the schools have programs to assist your children with their homework after school?

[1] yes [2] I don't know [3] no [4] not applicable

9. Do you participate in any of your child's school programs?

[1] no [2] sometimes [3] frequently [4] N/A

10. Are your children in a sport or recreational activities?

[1] yes [2] no [3] I don't know

11. Do you consider your community to be healthy?

[1] yes [2] no [3] I don't know

12. Can you identify the leaders in your community?

[1] yes [2] no [3] I don't know

names:

_____, _____
_____, _____
_____, _____

13. What organizations do you know that help your community?

_____

_____

_____

_____

14. Can you do something about your community?

[1] yes [2] no [3] I don't know

SECTION V. COMMUNITY PERCEPTIONS (continued)

15. What can you do for your community?

_____
_____
_____

16. What would you like to learn to improve your family's health?

_____
_____
_____

17. Would you like to attend any of the following free-of-charge classes?
(check as many as you like)

[1] women's health	[4] child safety	[7] AIDS
[2] CPR	[5] diabetes	[8] TB
[3] Nutrition	[6] high blood pressure	[9] other_____
		[10] not interested

18. Please comment on issues and problems in your community.

_____
_____
_____
_____
_____
_____

Opening Doors New Mexico
Community Health Worker Evaluation Project
University of New Mexico

I.1.1

CHW Practices Log*

Dates of Visits: _____
Number of Clients: _____
CHW ID #: _____

1. Please mark which of the following topics were discussed during the home visit:

Family planning _____
Pregnancy classes _____
Care after having a baby _____
Breastfeeding _____
Parenting classes _____
Breast/cervical cancer, screening _____
Other women's health _____
_____
Well baby checkups _____
School/Head Start _____
Immunizations _____
Lead poisoning _____
Child development issues _____
Teen pregnancy prevention _____
Abuse of drugs or alcohol _____
Sexually transmitted diseases _____
Family problems _____
Domestic violence _____
Child abuse _____
Gang violence _____
Accident prevention _____
Vaccinations/Medicine _____
Nutrition _____
Dental health _____
Smoking cessation _____
Illness _____

Diabetes _____
Prostate _____
Exercise _____
Senior services _____
Cancer support services _____
Public assistance _____
Access to health care _____
Obtaining food _____
Work _____
Housing _____
Financial _____
Transportation _____
Recreation _____
Sanitation _____
Civic/Political _____
Immigration _____
Monitor blood sugar _____
Blood pressure _____
Injections _____
Glucometer training _____
Transportation of medication/other health items
_____
Emotional support/encouragement _____
_____
Agency referral _____
Other (please describe) _____

2. Please mark each time that you helped a client with any of the following:

Filled out a form _____
Provided transportation _____
Gave them something _____
Loaned them something _____
Helped them do something _____
Helped them get something _____
Introduced them to someone _____
Explained something _____
Contacted someone _____

Suggested someone to contact _____
Suggested a book or pamphlet _____
Gave advice _____
Showed concern _____
Gave "moral support" _____
Encouraged them _____
Boosted their self-esteem _____
Other (please describe) _____
_____

** Form is available in Spanish*

3. Please mark each time that you referred a client to someone or somewhere else.

Health Department _____
Health clinic _____
Behavioral/Mental Health Services _____
Local hospital _____
Outside hospital _____
Senior services _____
Dental services _____
Vision services _____
Welfare Department _____
WIC _____

School/Head Start _____
Social Security _____
Housing Authority _____
Food bank _____
Private doctor _____
Nurse _____
Private counselor _____
Lawyer _____
Other service agency _____
Other (please describe) _____

4. Please mark each time you referred a client to any of the following special services:

Breast/cervical clinic _____
Diabetes clinic _____
Prenatal classes _____
Smoking cessation classes _____
Baby car seat program _____
Cancer support group _____
Parenting classes _____
Drug or alcohol abuse program _____

Job training program _____
Educational programs (T-VI, GED) _____
Commercial resources _____
Child assessment programs (Child Find) _____
Lead poisoning program _____
Commodities program _____
Other (please describe) _____
_____

5. Please mark the number of persons you have helped from the following groups during the past month.

	Hispanic/ Latino(a)	Anglo	Native American	American African	Asian
Babies (0-12 months)					
Boys (1-12 years)					
Girls (1-12 years)					
Teenage boys (13-18 years)					
Teenage girls (13-18 years)					
Men (19-54 years)					
Women (19-64 years)					
Senior Men (65+ years)					
Senior Women (65+ years)					

I.1.1

Opening Doors,
Tualatin, OR

Initial Data Record

Staff: _____ OD Office: _____ ❑ Sent to HSI, date: _____ ❑ Sent to Provider, date: _____

Name: _____ Date: _____
Address: _____
Social Security #: _____
Age: _____ DOB: _____ Referral source: _____
Telephone #: ( ) _____ Message #: _____
Occupation: _____ Full-time? _____ Part-time? _____
Place of birth: _____
If non citizen, status: _____
Ethnic origin: _____
Partner's name: _____

Do you live with the father of the baby?	Y	N
Are you legally married?	Y	N
Do you speak English?	Y	N

Pregnancy History:

How many times have you been pregnant? _____
Number of living children: _____
Number of elective abortions: _____
Number of spontaneous abortions: _____
Were there any problems with your previous pregnancies? _____
Were your other babies born healthy? _____
Names/DOB of other children: _____

Current Pregnancy

Last Menstrual Period: _____ Expected Date of Delivery: _____ Gest. in Weeks. _____
❑ Planned Preg ❑ Unintended ❑ Unwanted

Obstetrical Care:

Are you currently receiving prenatal care? ❑ Yes ❑ No
Gest. Mo. AP care began: _____
Date 1st visit: _____
Weeks waited for appt.: _____
OB Provider: _____
Insurance/payment status: _____
❑ OHP pending ❑ Open Card ❑ CAWEM ❑ Private Ins.
❑ Private Pay ❑ OHP, enrolled - Health Plan: _____
Choice of delivering hospital: _____
Are you interested in prenatal classes? ❑ Yes ❑ No
Arrangements made? ❑ Yes ❑ No Describe: _____

Assistance:

❑ On WIC	❑ Has not applied	❑ Pending	❑ Applied, not eligible
❑ On food stamps	❑ Has not applied	❑ Pending	❑ Applied, not eligible
❑ AFS (AFDC)	❑ Has not applied	❑ Pending	❑ Applied, not eligible
❑ Tribal Assistance	❑ Social security/disability		

Transportation:

❑ Has driver's license ❑ Has own car
❑ Depends on others for transportation ❑ Bus
❑ Walks ❑ OHP transportation
❑ No reliable transportation

Education and Employment:

❑ Years of formal education: _____
❑ Has completed GED
Currently employed: ❑ YES ❑ NO
Education/Employment Plans _____
Name of father of baby _____
Father employed ❑ YES ❑ NO
How do you plan to insure the father's continuing financial support for your baby?
_____

Financial Stressors:

❑ Behind in utilities ❑ Behind in rent ❑ Transportation
❑ Need to move ❑ Not enough food resources ❑ Inadequate income for maternity clothes/supplies
❑ Recent/chronic unemployment
❑ Overwhelming debts; explain: _____

Emotional Status:

Stressors during pregnancy: _____
What do you do when you feel stressed? _____
What does your partner do when he feels stressed? _____
Comments: _____

Social Support:

ASSESSMENT OF STRESS:

Please answer to what extent the following factors are current stressors/hassles.
Circle the number corresponding to the appropriate response.

To what extent are (read choice) a current stressor/hassle for you? Rate according to the following:	1=No Stress	2=Some Stress	3=Moderate Stress	4=Severe Stress
Financial worries (e.g., food, shelter, health care)	1	2	3	4
Other money worries (e.g., bills, etc.)	1	2	3	4
Problems related to family (partner, children, etc.)	1	2	3	4
Having to move, either recently or in the future.	1	2	3	4
Recent loss of a loved one	1	2	3	4
Current pregnancy	1	2	3	4
Current abuse, sexual, emotional and/or physical	1	2	3	4
Problems with alcohol and/or drugs	1	2	3	4
Work problems (e.g., being laid off, etc.)	1	2	3	4
Problems related to friends	1	2	3	4
Feeling generally "overloaded"	1	2	3	4

Score: _____

Risk Factors: Answer Yes or No

● Have you ever been a victim of domestic violence?	Y	N
● Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?	Y	N
● Since you've been pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone?	Y	N
● Within the last year, has anyone forced you to have sexual activities?	Y	N
● Are you afraid for your safety now?	Y	N
● Are you afraid for the safety of your children now?	Y	N
● Do you have a plan to keep you and your children safe?_____		
● Would you, like information about resources for victims of domestic violence?	Y	N
● Have you ever been treated for STD? Has the father of the baby?	Y Y	N N
● When was the last time you had a cigarette or used tobacco? _____		
● When was the last time you had any alcohol? _____		
● Does your partner drink alcohol?	Y	N
● Would you like information on alcohol treatment programs?	Y	N
● Have you ever used any drugs? _____		
● When was the last time you used drugs? _____ Substance used? _____ requency/Quantity? _____		
● Does your partner use drugs?	Y	N
● Would you like information about drug treatment programs?	Y	N
● Do you take any prescription or over-the-counter drugs? If yes, please list: _____ Do you take any of these drugs other than directed?	Y ❑ No	N ❑ No info
● Have you ever been involved with CSD? If so, why?/where (county)? _____	Y	N
● Are you interested in parenting classes?	Y	N
● Are you planning to breast feed your baby?	Y	N

Pediatric Care: Answer Yes or No

- Do you currently have a physician who takes care of your other children? Y N
  Who? _____
- Have you decided on a physician to take care of this baby? Y N
  Who? _____
- Do you have any needs we have not addressed thus far? Y N
  _____

I.1.2

Migrant Health Promotion,
Promoviendo Vidas Saludables, Texas
Children's Health Project

Health Individual Encounter Record*

Is this the first encounter with the client? Yes _____ No _____
Did you refer client to any other type of service? Yes _____ No _____

Note: This form to be filled by the Community Health Worker to document educational services provided.

1. **Date:** _____

2. **Name:** _____

3. **Age:** _____

4. **Sex:** Male _____Female _____

5. **Have you ever migrated for work purposes?**
   Yes _____ No _____

6. **Address:**
   Street _____
   City _____
   State _____
   Zip _____

6b. **Subdivision (Colonia):** _____

7. **May we contact you via telephone?**
   Yes _____ No _____

7b. **If yes, please provide your phone number:**
   ( ) _____

8. **Are you registered with any health clinic?**
   Yes _____ No _____

8b. **If yes, where?** _____

9. **Meeting with patient was held at:**
   Health Clinic _____
   Community Center _____
   Field _____
   Home _____
   Other (specify): _____
   _____

10.0 Education Information			
10.1 Prevention: Healthy Children	**10.0 Childhood Diseases**	**10.3 Children Social and Health Services**	**10.4 General Education**
____**a.** Regular health check-ups and immunizations ____**b.** How to keep your children for becoming ill ____**c.** Child development ____**d.** Fire safety and safety at home ____**e.** Nutrition ____**f.** Eye and dental care ____**g.** Lead poisoning	____**h.** Infectious diseases ____**i.** Throat infection ____**j.** Chicken pox, measles and whooping cough ____**k.** Asthma ____**l.** Cough ____**m.** Fever ____**n.** Ear aches ____**o.** Intestinal worms	____**p.** Medicaid ____**q.** WIC ____**r.** EPSDT ____**s.** Health Clinics ____**t.** Texas Lone Star Card	____**u.** Family Planning ____**v.** STD's ____**w.** HIV/AIDS ____**x.** Menopause ____**y.** Sexuality Education ____**z.** Domestic Violence ____**aa.** Breast Cancer ____**bb.** Cervical Cancer ____**cc.** Nutrition and Exercise ____**dd.** Diabetes ____**ee.** High Blood Pressure and Cardiovascular Disease ____**ff.** Tuberculosis ____**gg.** Other

10. Referrals

Referred to:	Reason	Is this the first time the client seeks help for this problem?
Agency: _____ Address: _____ Phone: _____	_____ _____ _____	Yes _____ No _____
Agency: _____ Address: _____ Phone: _____	_____ _____ _____	Yes _____ No _____

11. If this referral requires follow-up, did you indicate so in the "Referral and Follow-Up Form?

Yes _____ No _____

12. Health Individual Encounter conducted by: _____ **Date:** _____

(Name of Community Health Worker):

Arizona Department of Health Services
Health Start Program

I.2.1

Family Follow-Up Log Record

Lay Health Worker *(Please Print)* _____

Date of Visit _____/_____/_____

_____ _____ _____
Mother's Last Name First Name Middle Initial

Please complete the following items to record additional information about your encounter:

Breastfeeding goal:

Family Planning goal:

Transportation Needs/Arrangements:

Other notes:

I.2.1

*Form is available in spanish**

Migrant Health Promotion, *Promoviendo Vidas Saludables*

Referral and Follow-up Log*

Promotor/a: _____ **Program:** _____ **Month:** _____

The purpose of this log is to document referrals made during an Individual encounter, and to find out what happened after a referral was done. A referral must be followed-up with 1 to 3 calls/visits to find out what was the outcome of the referral.

Name of the Person Referred: (Document one referral per two if a person is referred to more than one agency.)	**Contact Information:** (Write the phone number or address of person referred. A person must be contacted at least 3 times to find out what happened with the referral or location where person can be found.)	**Reason for Referral:** (To what agency was the person referred to?)	**Dates of Follow-Up:** (Write the dates that you called or visited the person to find out what happened regarding this referral.)	**Outcome of Referral:** Circle the code number that best fits: 1. Unable to contact person after three contact attempts 2. Person did not go for services- why? 3. Person went for services - state what services were received. 4. Other
1			1st. _____ 2nd. _____ 3rd. _____	1 2 3 4 Comments:
2			1st. _____ 2nd. _____ 3rd. _____	1 2 3 4 Comments:
3			1st. _____ 2nd. _____ 3rd. _____	1 2 3 4 Comments:
4			1st. _____ 2nd. _____ 3rd. _____	1 2 3 4 Comments:
5			1st. _____ 2nd. _____ 3rd. _____	1 2 3 4 Comments:

Referral and Follow-Up Log was reviewed and approved by: _____ Date: _____
(Name of Program Coordinator):

Centro Comunitario Juan Diego
Chicago, IL

I.2.3

In-Home Pre-Presentation Form*

☑Check True or False to answer each question

1. Mosquitoes transmit HIV, the virus that causes AIDS	True	False
2. You can prevent getting HIV by practicing abstinence (no sexual intercourse).	True	False
3. A person can get HIV from an open mouth kiss (French kiss).	True	False
4. A person can be infected with HIV and not know it.	True	False
5. You can get HIV from a hug.	True	False
6. If a person tests positive for HIV, it means that he/she has AIDS.	True	False
7. HIV can be found in breast milk.	True	False
8. The use of drugs and alcohol can impair judgment, and make it more likely that a person will in engage in HIV risk behavior.	True	False
9. You can get HIV from toilet seats.	True	False
10. The use of latex condoms and spermicide can reduce the risk of getting or giving STDs, including HIV.	True	False
11. You can become infected with HIV by donating blood.	True	False
12. Persons with HIV, who feel healthy, can infect other people through sexual intercourse.	True	False
13. You can prevent getting HIV by washing after sexual intercourse.	True	False
14. AIDS has a cure if treated during early stages.	True	False
15. You can get HIV by eating from the same plate and drinking from the same glass.	True	False
16. HIV is found in blood, semen and vaginal fluids.	True	False

** Form is available in Spanish*

☑ **Check the boxes to mark your answers. Your answers are confidential. If you have any questions or need help filling out this questionnaire, please ask the Community Health Promoter.**

Age: _____ **Sex:** ❑ **Male** ❑ **Female**

Relationship Status:
- ❑ Single
- ❑ Married/Common Law
- ❑ Separated
- ❑ Divorced
- ❑ Widowed

Ethnicity:
- ❑ Puerto Rican
- ❑ Mexican
- ❑ Mexican-American
- ❑ African-American
- ❑ Central or South American
- ❑ White
- ❑ Asian
- ❑ Native American
- ❑ Other _____

☑ **Mark ONE response for each question.**

	Only Spanish	Spanish More than English	Both Equally	English More than Spanish	Only English
1. In general, what language do you read and speak?	❑	❑	❑	❑	❑
2. ...at home?	❑	❑	❑	❑	❑
3. ...think in?	❑	❑	❑	❑	❑
4. ...speak with your friends?	❑	❑	❑	❑	❑

Do you think your partner is currently at risk of contracting HIV?
❑ Yes ❑ No

Do you think you are currently at risk of contracting HIV?
❑ Yes ❑ No

How is the communication between you and your partner about sexuality?
- ❑ Very good
- ❑ There is no communication about sexuality
- ❑ It varies
- ❑ Difficult
- ❑ I am not sexually active

How is the communication between you and your children about sexuality?
- ❑ Very good
- ❑ There is no communication about sexuality
- ❑ It varies
- ❑ Difficult
- ❑ I do not have children

Do you know what a condom is?
❑ Yes ❑ No

Have you ever used one?
❑ Yes ❑ No

Why do you think people use condoms?
- ❑ To protect against Sexually Transmitted Diseases
- ❑ To avoid pregnancy
- ❑ To prevent HIV/AIDS
- ❑ Curiosity
- ❑ Because their friends use them
- ❑ Other (please explain):

_____

Why do you think people do NOT use condoms?

- ❑ They do not have enough information
- ❑ Condoms break easily
- ❑ Because their friends don't use them
- ❑ They don't want their partners to think s/he was unfaithful
- ❑ Condoms cause tension between partners
- ❑ Condom use spoils the mood
- ❑ They might have allergies
- ❑ They want to have a baby

Now we would like to ask you about some sensitive topics. We do not assume that all questions apply to you personally.

Which phrase currently best describes you best? Mark only one box.

- ❑ "My partner/spouse and I are planning on having children."
- ❑ "I am not sexually active."
- ❑ "I am in a monogamous relationship."
- ❑ "None of the above."

Which phrase currently best describes you best? Mark only one box.

- ❑ "I currently do not use condoms regularly, and I do not intend to start using them in the next 6 months."
- ❑ "I currently do not use condoms, but I am thinking about starting to use them in the next 6 months."
- ❑ "The next time I have sex, I will use a condom."
- ❑ "I currently use condoms regularly, but I have begun doing so only in the last 6 months."
- ❑ "I currently use condoms regularly and have done so for longer than 6 months."

Thank you for filling out this form.
Please wait for your Community Health Promoter to do the presentation.

Center for Healthy Communities
Wright State University, Dayton, OH

Community Health Advocate Survey

ID number: _____
Zip: _____
Telephone: _____
Interview: _____

Introduction:

Hello, (name), my name is _____. I am calling to ask you some questions about the Community Health Advocate Program. The Center for Healthy Communities is interested in finding out what the people who have worked with Community Health Advocates think of the program. Our records show that you have had contact with one of our advocates, (name of Advocate, if necessary). Would you mind taking about 10 minutes to answer some questions? Your answers will be kept confidential. Thank you.

(Circle the number corresponding to the response)

1. How did you learn about the Community Health Advocates?

1. Flyer
2. Neighbor/family/friend
3. Community Site
4. Other (specify) _____
9. Don't know/no answer

2. Why did you contact a Community Health Advocate?

1. General source of information
2. Help in paying utilities
3. Health needs (self)
4. Need for food
5. Health needs (child or children)
6. Other (specify) _____
9. Don't know/no answer

3. How did the Community Health Advocate help you? (Circle all that apply)

1. Gave me information on resources
2. Helped me fill out papers
3. Went to appointment with me
4. Found health resources (glasses, medical, dental, etc.)
5. Found food resources
6. Financial assistance
7. Other (specify) _____
8. Did not help me (skip to question 5)
9. Don't know/no answer

4. In thinking about you overall experience and using a scale from 1 to 5, how much were you helped by working with the Community Health Advocate?

Least helpful 1
If your answer is 1 or 2, go to question 5 2
3
If your answer is 3, 4, or 5, skip to question 6 4
Most helpful 5

5. If working with the Community Health Advocate was not very helpful, why not?

1. No resources available
2. Person was not eligible
3. Process for getting help too long
4. Other (specify) _____
9. Don't know/no answer

6. During the last 2 years, about how often have your worked with a Community Health Advocate? Has it been:

1. Once (skip to question 8)
2. Twice
3. 3 to 5 times
4. More than 5 times
9. Don't know/no answer

7. Were these contacts with the Advocate related to just one need you had or more than one need?

1. One
2. More than one

8. Have you ever had trouble getting in touch with the Advocate when you needed to?

1. No
2. Yes (If yes, specify reason below)

_____
_____

9. Would you recommend working with an Advocate to someone else?

1. No
2. Yes

(if no, ask why not and record below. Record any other comments)

10. What have you liked most about working with the Advocate?

_____
_____
_____
_____
_____

11. What didn't or don't you like about working with the Advocate?

_____
_____
_____
_____
_____

12. Are there other places in the community that it would be good to have an Advocate? If so, where?

_____
_____
_____
_____

Thank you for your answers. Now I'd like to ask you some questions about yourself.

13. How old are you?

1. 11-18 years
2. 19-30 years
3. 31-50 years
4. 51-50 years
5. 61 years or over
9. Refused/no answer

14. (Circle sex of respondent)

1. Female
2. Male

15. Would you describe yourself as:

1. African-American
2. White
3. Hispanic
4. Asian
5. Native American
6. Other (specify)
10. Refused/no answer

16. Where are you most likely to get information about health, health programs, or other information? For each place I name, please respond on a scale from 1 to 4, with 4 being most likely and 1 being least likely.

	Least			Most
Television	1	2	3	4
Radio	1	2	3	4
Newspaper	1	2	3	4
Friend/family/neighbor	1	2	3	4
Mailings	1	2	3	4
Church	1	2	3	4
Community Health Advocate	1	2	3	4
(specify other)				

17. Are there any other services that you think need to be available in the community?

_____
_____
_____
_____
_____

Thank you for taking the time to answer these questions. Again, you answers will be kept confidential and will not be reported individually, but only as part of a group.

Department of Health Policy and Management
The Johns Hopkins University School of Hygiene and Public Health

I.2.4

Community Health Worker Satisfaction Questionnaire

Good day. Mr./Ms._____

We want your opinion on the Community Health Worker services. Please choose the answer that is closest to your opinion. There are no right or wrong answers. We want your opinion so that we can continue to serve you better. How would you rate the following qualities of the community health worker:

	Poor	Fair	Good	Very Good	Excellent	Does not apply
1. The worker's honesty						
2. The respect the worker shows						
3. How caring and concerned the worker is						
4. The time the worker takes with you						
5. How pleasant the worker is						
6. How well the worker listens to you						
7. How comfortable you feel with the worker						
8. How dependable the worker is						
9. How busy the worker seems						
10. The workers attitude in general						

Thinking about the things that the health worker does, would you rate the worker for each of the following activities: _____

	Poor	Fair	Good	Very Good	Excellent	Does not apply
11. Giving you information about high blood pressure						
12. Being clear when giving you information						
13. Telling you what your blood pressure reading is						
14. Taking your blood pressure						
15. Reminding you to take your medicines						
16. Discussing with you what happened at your last doctor's visit						
17. Reminding you to keep your next doctor's visit						
18. Stressing the importance of keeping your doctor visit						
19. Asking you about whether you keep your doctor's visits						
20. Giving you information on healthy eating						

Thinking about the health worker visits, how would you rate the following:

	Poor	Fair	Good	Very Good	Excellent	Does not apply
21. How helpful the worker is in keeping you alive						
22. How helpful the worker is in reducing your blood pressure						
23. How helpful the worker is in improving your medical care						
24. How helpful the worker is in getting you services that you need						
25. How helpful the worker is when you apply for medical or pharmacy assistance						
26. How helpful the worker is when you have problems with your medicines						
27. How helpful the worker is to you maintaining your health						
28. How helpful the worker is in finding you a doctor						
29. How helpful the worker is with your other health problems (not high blood pressure)						
30. How well the worker encourages you to be healthier						

Thinking about the way the health worker and the home visits,how would you rate the following:

	Poor	Fair	Good	Very Good	Excellent	Does not apply
31. How easy it is to reach the worker						
32. How helpful the worker is in saving you money						
33. The number of workers that visit you						
34. How well the worker knows her job						

Thinking about the health worker in general, how would you rate the following

	Poor	Fair	Good	Very Good	Excellent	Does not apply
35. How would you rate the quality of the services you received from the health worker overall						

Would you say that the following statements were true: Always, Most of the time, sometimes, or Never.

36. My community health worker lets me down

Always	Most of the time	Sometimes	Never
❑	❑	❑	❑

37. My community health worker seems too busy for me

Always	Most of the time	Sometimes	Never
❑	❑	❑	❑

38. I feel comfortable with the community health worker

Always	Most of the time	Sometimes	Never
❑	❑	❑	❑

39. I appreciate the community health worker

Always	Most of the time	Sometimes	Never
❑	❑	❑	❑

40. Thinking about the health worker services overall, how much could be better?

Many things	A few things	One or two things	Nothing could be better at all
❑	❑	❑	❑

41. How many workers did you see _____

42. Thinking about the worker you saw most often, would you recommend this health worker to a friend or relative who has a similar health condition

Definitely not	Probably not	Not sure	Probably yes	Definitely yes
❑	❑	❑	❑	❑

43. How good an idea it is to have health workers visit people with health conditions like yours

Poor	Fair	Good	Very Good	Excellent
❑	❑	❑	❑	❑

I. 2.4

Healthier Communities Department of Spectrum Health
Mothers Offering Mothers Support Program (MOMS)
Maternal Support Services

Program Evaluation

(1 month in the program)

MOMS ID# ☐☐☐☐☐-☐☐ **Date:** ☐☐-☐☐-☐☐
PPA ID# ☐☐☐☐-☐☐ **VOL ID#** ☐☐☐☐-☐☐

Please help us better our program by answering some questions about the maternal support services you have been getting. We are interested in your honest answers, whether they are positive or negative. Please answer all of the questions.

PROGRAM

1. How would you rate the quality of service you have been receiving?

☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Great

2. Are you getting the kind of service you want?

☐ Never ☐ Sometimes ☐ Not sure ☐ Usually ☐ Always

3. To what extent is this program meeting your needs?

☐ None of my needs have been metmet ☐ Only a few of my needs have been met ☐ Some of my needs have been met ☐ Most of my needs have been met ☐ Almost all of my needs have been

4. If a friend were in need of similar help, would you recommend this program to her?

☐ No ☐ I don't think so ☐ Not sure ☐ I think so ☐ Yes

5. If you were to seek help again, would you come back to this program?

☐ No ☐ I don't think so ☐ Not sure ☐ I think so ☐ Yes

6. What do you need from the program to help you? _____

_____

_____

ADVOCATE SUPPORT Questions 7 to 14 refer to your relationship with _____
(CHN/advocate's name)

7. For me, this support relationship is:

☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Great

If you marked 1;2 or 3, indicate why you think this is so (check all that apply):

☐ She is hard to talk to ☐ She is too busy ☐ Other
☐ My problems are too much for her ☐ She is uncomfortable with relationship

_____

8. Contacting your advocate is:

☐ Difficult ☐ Somewhat difficult ☐ Neither difficult nor easy ☐ Somewhat easy ☐ Easy

If you marked 1.2 or 3, Indicate why you think this is so (check all that apply):

☐ She does not return my phone calls ☐ She is never in the office

☐ She doesn't get my messages ☐ Other _____

_____

9. Talking with your advocate is:

☐ Difficult ☐ Somewhat difficult ☐ Neither difficult nor easy ☐ Somewhat easy ☐ Easy

If you marked 1.2 or 3, indicate why you think this is so (check all that apply):

☐ She is real quiet ☐ She doesn't seem interested ☐ Other

☐ She doesn't understand my problems ☐ She doesn't listen

10. Do you like this advocate? ☐ Yes ☐ No

11. Do you think your advocate likes you? ☐ Yes ☐ No

12. Do you feel your advocate understands you?

☐ Never ☐ Sometimes ☐ Not sure ☐ Usually ☐ Always

13. Do you feel your advocate is helping you?

☐ Never ☐ Sometimes ☐ Not sure ☐ Usually ☐ Always

14. What do you need from your advocate to help you? _____

_____

VOLUNTEER SUPPORT Questions 15 to 23 refer to your relationship with _____
(volunteer's name)

15. For me, this support relationship is:

☐ Poor ☐ Fair ☐ Average ☐ Good ☐ Great

If you marked 1, 2 or 3, indicate why you think this is so (check all that apply):

☐ She is hard to talk to ☐ She is too busy ☐ Other

☐ My problems are too much for her ☐ She is uncomfortable with relationship

_____

16. Contacting your volunteer is:

☐ Difficult ☐ Somewhat difficult ☐ Neither difficult nor easy ☐ Somewhat easy ☐ Easy

If you marked 1, 2 or 3, indicate why you think this is so (check all that apply):

☐ She has no phone ☐ She does not return my phone calls

☐ She is never home ☐ She doesn't get my messages

☐ Other _____

17. Talking with our volunteer is:

☐ Difficult ☐ Somewhat difficult ☐ Neither difficult nor easy ☐ Somewhat easy ☐ Easy

If you marked 1, 2 or 3, indicate why you think this is so (check all that apply):

☐ She is real quiet ☐ She doesn't understand my problems

☐ She doesri1 seem interested ☐ She doesn't listen

☐ Other _____

18. Do you like this volunteer? ☐ Yes ☐ No

19. Do you think your volunteer likes you? ☐ Yes ☐ No

20. Do you feel your volunteer is like you? ☐ Yes ☐ No

21. Do you feel your volunteer understands you?

☐ Never ☐ Sometimes ☐ Not sure ☐ Usually ☐ Always

22. Do you feel your volunteer is helping you?

☐ Never ☐ Sometimes ☐ Not sure ☐ Usually ☐ Always

23. What do you need from your volunteer to help you?_____

_____

24. Do you have any other comments or concerns? _____

_____

_____

Juntos Contra el Cancer
University of Arizona
Santa Cruz County, AZ

I.2.4

Promotor/a Evaluation

Contact Form #: _____
Date: _____
Time Began: _____
Time End: _____
Initials: _____

Hi, my name is _____ from the University of Arizona. Last year you were visited by _____, a promotor/a. I work with the promotor/a project too and I'd like to spend a few minutes talking to you about it. Is now a good time to talk? Good, it will only take a few minutes.

(Once inside)
I'm going to be asking you a series of questions about the promotor/a project. (Promotor/a's name) has not discussed with me anything you two spoke about. All of the information you give to me will be strictly confidential and will only be reported in general terms, your name or the promotor/a's name will never be used. This information will, be used to help design better promotor/a programs to meet the needs of women in the community.

1. **When did you meet your promotor/a for the first time?** _____

_____

_____

_____

2. **What do you remember about her first visit?** _____

_____

_____

3. **What language did you speak with the promotor/a?** _____
(If Spanish, ask question #4)
(If English, ask question #5)

4. **Do you prefer to speak Spanish, or do you only speak and understand Spanish?** _____

_____

_____

5. In what ways did your promotor/a help you? _____

_____

_____

6. What did you learn about cancer in general? _____

_____

_____

7. What did you learn about cervical cancer? _____

_____

_____

8. What did you learn about pap tests (or smears)? _____

_____

_____

(Probe: anything else?)

9. Would you have known where to go for a Pap test if your promotor/a had not visited you?

(If yes: where?) _____

10. Have you ever had a Pap test?
Yes_____ No _____
(If yes: continue with question #11.)
(If no, go to question #21.)

11. When did you get your last Pap test?
Date _____

12. Did you make the appointment for your Pap test or did your promotor/a make it?
(Check the appropriate response)
Contact made appt. _____ Promotor/a made appt. _____

13. Before that exam, how many years had it been since you had a Pap test?

_____

14. **(Interviewer: if question #11 is more than a year ago): why was there so much time between that appointment and your most recent one?**

_____

_____

(Probe) was there some particular reason or something that kept you from going?

_____

_____

15. **Why did you get your Pap test?** _____

_____

_____

16. **Where did you go for your Pap test?** _____

_____

_____

17. **What was it like? What were your feelings about it?** _____

_____

_____

(Probe': how were you treated there?) _____

_____

_____

18. **Did you feel comfortable with the staff?** _____

_____

_____

19. **What were the results of your clinic visit?**
(If she does not mention Pap test, probe: what were the results of your Pap test?)

_____

_____

20. **If you had not met your promotor/a would you have gone for a Pap test?**
Yes_____ No _____
(If no:) why not?

21. Are you going to get a Pap test in the coming year?

(If yes) why? _____

_____

(If no) why not? _____

_____

22. What did you talk with your promotor/a about during her visits or phone calls? _____

_____

_____

_____

(Probe: if interviewee does not discuss any of the following subject areas in question 17, ask specifically:)

Did you talk with your promotor/a about:

Breast Cancer	Yes _____	No _____
Mammograms	Yes _____	No _____
Breast Self-Exam	Yes _____	No _____
Diabetes	Yes _____	No _____
Heart Disease	Yes _____	No _____
High Blood Pressure	Yes _____	No _____
Family Problems	Yes _____	No _____
Family Planning	Yes _____	No _____
Health Programs	Yes _____	No _____
Other Social Services	Yes _____	No _____
Drugs	Yes _____	No _____
HIV/AIDS	Yes _____	No _____
Insurance	Yes _____	No _____
(IF YES: Did your promotor/a help you get on ACCCHS?	Yes _____	No _____
If you already had ACCCHS or other insurance, did she help you with any insurance problems?	Yes _____	No _____
Other	Yes _____	No _____

23. What was most helpful to you about your discussions with your promotor/a? _____

_____

_____

24. Did you talk to any of your friends or relatives about any of the issues discussed with the promotores/as?
Yes_____ No _____

If yes, what did you talk about? _____

_____

_____

25. What are your greatest health concerns? _____

_____

_____

26. What are your greatest concerns for you and your family? _____

_____

_____

27. Were you able to talk to your promotor/a about confidential matters?
Yes_____ No _____
(If they respond write in response)

Now, I would like to ask you a few more questions about you and members of your household.

28. In what country were you born?
(Put a check next to correct answer. Write in name of country next to specify if other than USA or Mexico.)
USA _____ Mexico _____ Other (specify) _____

29. In what city and state were you born? _____

_____

_____

30. How long have you lived in the United States?
Years _____ months _____

31. Do you have any children?
Yes_____ No _____

32. How many? _____

33. How old is your youngest child? _____

_____

_____

34. What is your birth date? Month _____ Day _____ Year _____

35. How many family members are living with you in your household? _____

36. Which of the following best describes your current employment situation? (one answer only) (read the list) (please circle code to correct answer)

Employed, work full time	01
Employed, work part time	02
Employed, on maternity leave	03
Laid off or on strike	04
Unemployed and looking for work	05
Unemployed and not looking for work	06
Retired	07
Housewife only	08
Unable to work (disabled)	09
Full time student	10
Part time student	11
Don't know	88
Refused to answer	99

37. Now we would like to know how much your family's total combined income from all family members was during the past 12 months. This includes income from all sources, such wages, salaries, social security or retirement benefits, interest or dividends, rent food stamps, and so forth. Can you tell me if it was (read the list and mark one).

Under $6,000	01
Or $6,000 to $9,999	02
Or $10,000 to $19,999	03
Or $20,000 to $29,999	04
Or $30,000 to $39,999	05
Or $40,000 or more	06

38. Do you have medical insurance?

Yes_____ No _____

(If yes, mark the ones that apply to you.)

Medicare A or B 01
AHCCCS (Medicaid) 02
Coverage for military personnel and their
Families (veterans, CHAMPUS) 03
Private insurance (including HMO's (Cigna, partners,
GHMA, Intergroup, etc.) 04

Other 05
Specify
_____

39. Is there anything else you would like to tell us about the promotora project? _____

_____

_____

_____

Again, thank you for your time and assistance in helping us learn how to improve other promotora programs.

Interviewer comments:

Opening Doors New Mexico
Community Health Workers Evaluation Project
University of New Mexico

Client Questionnaire*

Date: _____
CHW ID # _____

1. How did it happen that you received help from the community health worker?
(Please circle best answer.)

a. Recommended by someone at a clinic or doctor's office
b. Recommended by someone at another agency
Which one?
_____

c. Recommended by a friend or acquaintance
d. Recommended by a relative
e. Your own idea
f. The community health worker came on their own initiative.
g. Other _____

2. I went to see or was referred to the community health worker for...

❑ Family planning
❑ Pregnancy classes
❑ Care after having a baby
❑ Breastfeeding
❑ Parenting classes
❑ Breast/cervical cancer, screening
❑ Other women's health
❑ Well baby checkups
❑ School/Head Start
❑ Immunizations
❑ Lead poisoning
❑ Child development issues
❑ Teen pregnancy prevention
❑ Injections
❑ Abuse of drugs and/or alcohol
❑ Sexually transmitted diseases
❑ Family problems
❑ Obtaining food
❑ Child abuse
❑ Gang violence
❑ Accident prevention
❑ Vaccinations Medicine
❑ Nutrition
❑ Dental health
❑ Smoking cessation
❑ Illness
❑ Diabetes
❑ Prostate
❑ Exercise
❑ Senior services
❑ Cancer support services
❑ Public assistance
❑ Monitor blood sugar
❑ Access to health care
❑ Blood pressure
❑ Work
❑ Housing
❑ Financial
❑ Transportation
❑ Recreation
❑ Sanitation
❑ Civic/Political
❑ Immigration
❑ Glucometer training
❑ Transportation of medication/other health items
❑ Emotional support/ encouragement
❑ Domestic violence
❑ Agency referral
❑ All Other (please describe)
_____

_____

** Form is available in Spanish*

3. How comfortable do you feel doing the following? (Please circle the best answer for each question.)

	Very comfortable	*Somewhat comfortable*	*Not very comfortable*	*I don't have to do this*
a. Knowing why I need a repeat PAP smear	1	2	3	4
b. Doing a breast self-exam	1	2	3	4
c. Calling the community health worker for help	1	2	3	4
d. Knowing how to take my medication	1	2	3	4
e. Breastfeeding my baby	1	2	3	4
f. Knowing what will happen during my colposcopy	1	2	3	4
g. Knowing where to go to apply for WIC	I	2	3	4
h. Caring for my baby	1	2	3	4
i. Knowing what to expect during labor	1	2	3	4
j. Making food choices that keep my blood sugars in control	1	2	3	4
k. Knowing the benefits of exercise in controlling blood sugar	1	2	3	4
l. Checking my blood sugar	1	2	3	4
m. Knowing how to take care of low blood sugar	1	2	3	4

4. How much sympathy or concern did the community health worker show to you?

a. A lot **b.** Some **c.** Hardly any **d.** None

5. How much did the community health worker help by suggesting ways you could take care of your problem yourself?

a. A lot **b.** Some **c.** Hardly any **d.** None

6. How much assistance with transportation, filling out forms, etc., did the community health worker give you?

a. A lot **b.** Some **c.** Hardly any **d.** None

7. What other things did she/he do to help you that I haven't mentioned? _____

_____

_____

8. Would you go to her/him for help again?

a. Yes **b.** No

9. Would you recommend her/him to others needing help?

a. Yes **b** No

Thank you very much for taking the time to answer these questions. The health advisors will use the things you and others have said during these interviews to improve the services they provide in the community.

Is there anything else you want to say or ask about the community health advisors, or this interview?

_____

_____

Centro Comunitario Juan Diego
Chicago, IL

I.3.1

Post Presentation Form*

☑ **Please answer the questions below by putting a check in the box to mark your answers. Your answers will be confidential.**

Did you watch a video about HIV/AIDS?
- ❑ Yes, Name of Video: _____
- ❑ No

What is your opinion of the video?
- ❑ Very interesting
- ❑ Interesting
- ❑ Not very interesting

Did you receive any of the following?
(check all that apply)
- ❑ Pamphlets/handouts
- ❑ Male condoms
- ❑ Female condoms
- ❑ Lubricating jelly
- ❑ Other: (specify) _____

Check the ones that you need more of.
- ❑ Pamphlets/handouts
- ❑ Male condoms
- ❑ Female condoms
- ❑ Lubricating jelly
- ❑ Other: (specify) _____

Compared to before the presentation, would you say you learned something new about HIV/AIDS?
- ❑ Yes ❑ No

How did you find the information? I understood...
- ❑ Most things or everything
- ❑ Some, but not all
- ❑ Very little

From what you learned in this presentation, what was the most important or useful information for you and your family?
- ❑ Communicating information to my family
- ❑ Learned modes of HIV transmission
- ❑ Prevention techniques
- ❑ Learned how to identify my risk factors
- ❑ I learned nothing

Mark the way in which you are MOST likely to use this information
- ❑ In my relationship with my spouse/partner
- ❑ Share it with my children
- ❑ Share it with other family members (extended family members)
- ❑ Share it with my friends and neighbors
- ❑ Another way (please specify): _____

After the presentation, do you think you are currently at risk of contracting HIV?
- ❑ Yes ❑ No

After the presentation, do you think your partner is currently at risk of contracting HIV?
- ❑ Yes ❑ No

If you would like more information or a referral for other services, please fill out the spaces below with your name and address.

Name: _____

Address: _____

Telephone: _____

Would you like to recommend us to a friend or family member?
❑ Yes ❑ No

☑ Check True or False to answer each question

1.	Mosquitoes transmit HIV, the virus that causes AIDS	True	False
2.	You can prevent getting HIV by practicing abstinence (no sexual intercourse).	True	False
3.	A person can get HIV from an open mouth kiss (French kiss).	True	False
4.	A person can be infected with HIV and not know it.	True	False
5.	You can get HIV from a hug.	True	False
6.	If a person tests positive for HIV, it means that he/she has AIDS.	True	False
7.	HIV can be found in breast milk.	True	False
8.	The use of drugs and alcohol can impair judgment, and make it more likely that a person will in engage in HIV risk behavior.	True	False
9.	You can get HIV from toilet seats.	True	False
10.	The use of latex condoms and spermicidal can reduce the risk of getting or giving STDs, including HIV.	True	False
11.	You can become infected with HIV by donating blood.	True	False
12.	Persons with HIV, who feel healthy can infect other people through sexual intercourse.	True	False
13.	You can prevent getting HIV by washing after sexual intercourse.	True	False
14.	AIDS has a cure if treated during early stages.	True	False
15.	You can get HIV by eating from the same plate and drinking from the same glass.	True	False
16.	HIV is found in blood, semen and vaginal fluids.	True	False

Now we would like to ask you about some sensitive topics.
We do not assume that all questions apply to you personally. Please answer as best as you can.

The next time you have intercourse, will you use a condom?

❑ Yes ❑ No

Do you plan to start using condoms in the next six months?

❑ Yes ❑ No

Thank you for participating in our program.

Planned Parenthood of Los Angeles in collaboration with
Hathaway Family Resource Center
Promotores/as Comunitarios Training Program

I.3.2

❑ Pre-Exam* ❑ Post-Exam*

Name: _____ Date: _____

Please read each question carefully and choose the appropriate answer.
Relax, concentrate and good luck.

Self- Esteem

1. **What is self-esteem?**

_____

_____

2. **Name three factors that lower self-esteem.**

_____ _____ _____

3. **Name three factors that help raise self-esteem.**

_____ _____ _____

4. **What is the difference between self-esteem and self-concept?**

_____

_____

5. **An insecure person possibly has a low self-esteem.**
True _____ False _____

Explain your answer: _____

_____

Communication Skills

6. **Name the two types of communication:**

_____ _____

7. **Name two things that can affect a message from being understood correctly:**

_____ _____

** Form is available in Spanish*

8. Identify from the following examples the style of communication that the person is using:

a. "Don't you see that I am tired, bring me the chair?'
This form of communication is: _____

b. "Oh, how my feet hurt, if only I had a chair"
This form of communication is: _____

c. "Can you please give me the chair that is next to you."
This form of communication is: _____

9. What is the difference between listening, and hearing?

_____

_____

10. Make the following example into an "I" Statement:
Leave me alone!

When: _____

I feel: _____

Then: _____

I would prefer: _____

Values and Sexuality

11. What are values?

_____

_____

12. Name three sources where we receive values about sexuality:

a. _____
b. _____
c. _____

13. Name two examples of values related to sexuality:

a. _____
b. _____

14. A girl can be born without a hymen: True _____ False _____

15. Our values never change: True _____ False _____

How to speak to our children about sexuality

16. Why is it important to speak to your children about sexuality?

_____

_____

17. Write an example of possible messages that are received from each category.

Faith Community/Church: _____ Friends: _____
Media/Television: _____ Parents: _____

18. Respond to the following situation taking into consideration the age of the child. Situation: Your 5 year-old child asks, "how are babies made?"

Your answer:

_____

_____

19. When does sexuality begin for a human being?

a. At 1 year old
b. During adolescence
c. Birth
d. Pre-adolescence

20. In children, self-exploration of their sexual organs is a normal behavior:

True _____ False _____

Female and Male Anatomy

21. What is the function of the clitoris? _____

_____

22. Sperm and testosterone are produced in: _____

_____

23. Explain the menstrual cycle: _____

_____

_____

24. Name two male organs that produce the fluid that makes up semen:

_____ _____

25. A woman can become pregnant even if her partner withdrawals his penis and ejaculates outside of her body.

True _____ False _____

Why? _____

_____

Birth Control Methods

26. Name three hormonal birth control methods:

a. _____
b. _____
c. _____

How do these protect a woman from pregnancy? _____
_____

27. Name the four birth control categories:

a. _____
b. _____
c. _____

28. Which methods help us to know our own fertility?

_____

29. Name three barrier methods:

a. _____
b. _____
c. _____

30. Which of the following combinations would be most effective in protecting against pregnancy and sexually transmitted infections?

a. Condom and foam
b. Female condom and male condom
c. Condom and the pill
d. The I.U.D and the pill

Sexually Transmitted Infections (STI's)

31. Name the four STI categories:

a. _____
b. _____
c. _____

32. What is the most common symptom of STI's? _____

33. Under what category are genital warts? _____

34. What symptoms would a woman with chlamydia have? _____

35. Name two ways of being infected with pubic lice: _____

HIV / AIDS

36. What do the initials stand for?

H _____
I _____
V _____

A _____
I _____
D _____
S _____

37. Name three ways of being infected with HIV:

a. _____
b. _____
c. _____

38. What are the four fluids where HIV lives?

a. _____
b. _____
c. _____
d. _____

39. Define "window period": _____
_____

40. What is the difference between HIV and AIDS? _____
_____

Prenatal Care

41. During pregnancy, the correct name for an 8-week old fetus is:

_____

42. Name the three signs of labor:

a. _____
b. _____
c. _____

43. Name three signals that indicate a possible pregnancy:

a. _____
b. _____
c. _____

44. When a fetus is growing inside the uterus it is being nurtured by the:

a. Amniotic bag
b. Placenta and umbilical cord
c. Uterine lining
d. Stomach walls

45. What is the name of the milk that first comes out of the mother's breast?

_____

Menopause

46. What is menopause? _____

_____

47. Name three signs that signal to a woman that she is in menopausal state:

a. _____
b. _____
c. _____

48. Why does a woman feel so many hot flashes during menopause? _____

_____

_____

_____

49. A woman can become pregnant during pre-menopause:

True _____ False _____

50. What does Premarin do to a woman's body?

_____

_____

Domestic Violence

51. Name three types of domestic violence.

_____ _____ _____

52. What are the three stages of the cycle of violence?

_____ _____ _____

53. What is a restriction order? _____

_____

_____

54. If a woman wants to escape from an abusive relationship, what should she take with her? Write two examples:

_____ _____

55. What type of abuse is it when a person is being yelled at and is being offended?

a. Economic
b. Physical
c. Emotional
d. Isolation

Alcohol and Drug Abuse

56. What category is cocaine under?

a. Inhalants
b. Stimulants
c. Narcotics
d. Depressives

57. What category is heroin under?

a. Inhalants
b. Stimulants
c. Narcotics
d. Depressives

58. What are "COOLS"?

a. Cigarettes dipped in heroine
b. Cigarettes dipped in acid
c. Cigarettes dipped in PCP
d. Cigarettes dipped in cocaine

59. What is the name of the synthetic drug that is strictly prescribed to people who want to end their heroine addiction?

a. Codeine
b. Methadone
c. Low doses of Marijuana
d. Viagra

60. What is the drug most commonly used in the United States?

a. Marijuana
b. Cocaine
c. Tobacco
d. Alcohol

Child Abuse

61. Write three examples of physical abuse.

_____ _____ _____

62. Write three examples of negligence.

_____ _____ _____

63. Write three examples of sexual abuse.

_____ _____ _____

64. Who is obligated by law to report suspected child abuse cases?

Give three examples:

_____ _____ _____

65. If a person obligated to report does not report a child abuse case, that person can be sent to jail for six months, pay a $1,000 fine or do both.

True _____ False _____

Optional

How was the exam? Why?

_____

_____

_____

Easy _____ **Difficult** _____ **Regular** _____

Thank you

Arizona Department of Health Services
Health Start Program

I.3.3

Family Follow-up Encounter Form

ID Number _____ Lay Health Worker _____ Today's Date _____

Mother's Last Name	First Name	Maiden Name	Date of Birth

Dates of Attempted Visits
_____/_____/_____ _____/_____/_____ _____/_____/_____ _____/_____/_____

New Address: (if applicable) _____

New Pregnancy?
Yes ❑ No ❑
_____/_____/_____
Expected Date of Delivery:

Length of Visit: ❑
(in minutes) _____

No Visit ❑

PROGRAM STATUS:

CONTINUING
❑ Continuing Family Follow-Up

CLOSED
❑ Refused Family Follow-Up
❑ Withdrew from Program
❑ Transferred to Other Site
❑ Completed Family Follow-Up
❑ Dropped from Program
❑ Lost to Follow-Up/Moved
❑ Referred to Other Program

If the case is being closed due to a death, please check the applicable:

❑ Child's death
❑ Mother's date

SOURCES OF INCOME:
❑ Own full-time job
❑ Partner, part-time job
❑ Social Security
❑ Disability
❑ Own part-time job
❑ Other household member job
❑ Alimony
❑ Unknown
❑ Partner, full-time job
❑ AFDC
❑ Child support
❑ Other

PLACE OF MEETING:
❑ Not Applicable
❑ Neighbor's Home
❑ Clinic
❑ Hospital
❑ Other
❑ Mother's Home
❑ Relative's Home
❑ Community Center
❑ School
❑ LHW's Home
❑ Program Office
❑ Social Event
❑ Telephone Visit

EDUCATION TOPICS DISCUSSED:

❑ Health Start program	❑ Emotions/Feelings	❑ Labor/Delivery
❑ Women's Health	❑ Unmet Needs	❑ Maternal Diet
❑ Maternal High Risk Conditions	❑ Child High Risk Conditions	❑ Parenting Skills
❑ Hearing/Vision Testing	❑ Breastfeeding	❑ Family Planning
❑ Smoking/Alcohol	❑ Abuse/Domestic Violence	❑ Transportation
❑ Child Nutrition/Diet	❑ Early Childhood Education	❑ Child's Health & Development
❑ Safety	❑ Prenatal Care	❑ Infant Care
❑ Immunizations	❑ Finances	❑ Changes after Pregnancy
❑ Changes during Pregnancy	❑ Educational Programs - Parent	❑ Other

TRANSPORTATION ASSISTANCE:

❑ Tokens/Passes	❑ Cab Arrangements	❑ Community Arrangements
❑ Transportation Available	❑ None Needed	

	Receiving	Waiting	Denied	Referred	Barriers
DCSE	❑	❑	❑	❑	❑
CPS	❑	❑	❑	❑	❑
AHCCCS	❑	❑	❑	❑	❑
Unemployment	❑	❑	❑	❑	❑
AFDC	❑	❑	❑	❑	❑
Food Stamps	❑	❑	❑	❑	❑
WIC	❑	❑	❑	❑	❑
CSFP	❑	❑	❑	❑	❑
Food Bank	❑	❑	❑	❑	❑
AzEIP	❑	❑	❑	❑	❑
SSA	❑	❑	❑	❑	❑
Other Prenatal Prgm	❑	❑	❑	❑	❑
Employment	❑	❑	❑	❑	❑
Transportation	❑	❑	❑	❑	❑
Child Care Services	❑	❑	❑	❑	❑
Early Childhood Ed	❑	❑	❑	❑	❑
Edult Ed	❑	❑	❑	❑	❑
Prenatal Classes	❑	❑	❑	❑	❑
Parenting Classes	❑	❑	❑	❑	❑
Breastfeeding Classes	❑	❑	❑	❑	❑
Other	❑	❑	❑	❑	❑

	Receiving	Waiting	Denied	Referred	Barriers
Referral to Community Resources:					
Prenatal Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	❑
Well Baby Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	❑

	Receiving	Waiting	Denied	Referred	Barriers
Referral to Community Resources:					
Primary Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	❑
Immunizations CHD CHC MSP IHS OTH	❑	❑	❑	❑	❑
Family Planning CHD CHC MSP IHS OTH	❑	❑	❑	❑	❑
Dental Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	❑
Nursing Care CHD CHC MSP IHS OTH	❑	❑	❑	❑	❑
Mental Health Services CHD CHC MSP IHS OTH	❑	❑	❑	❑	❑
Social Services CHD CHC MSP IHS OTH	❑	❑	❑	❑	❑
Hearing/Vision CHD CHC MSP IHS OTH	❑	❑	❑	❑	❑
Genetic Services CHD CHC MSP IHS OTH	❑	❑	❑	❑	❑

BARRIERS: 1= Not Available 2= Language 3= Transportation 4= Client Refusal 5= Other

INDEX CHILD IMMUNIZATION STATUS:			
Records checked?	Yes ❑	No ❑	Unknown ❑
Age appropriately immunized?	Yes ❑	No ❑	Unknown ❑
Series complete?	Yes ❑	No ❑	Unknown ❑

Please list below any childhood diseases contracted by the index child since the last visit:

QUESTIONS:			
Is this 2 year follow-up visit?	Yes ❑	No ❑	Unknown ❑
Note: If Yes, please submit the Family Immunization Roster			
Is the client breastfeeding/	Yes ❑	No ❑	Unknown ❑
Family planning goal changed?	Yes ❑	No ❑	Unknown ❑
Child's milestones discussed?	Yes ❑	No ❑	Unknown ❑
Child had well child checks?	Yes ❑	No ❑	Unknown ❑

Date of next well child checkup:

Arizona Department of Health Services
Health Start Program

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Prenatal Outcome Form

ID Number _____ Lay Health Worker _____ Today's Date _____/_____/_____

Mother's Last Name	First Name	Maiden Name	Date of Birth
_____	_____	_____	_____/_____/_____

BABY INFORMATION:

Baby's Last Name	First Name	Middle Name	Date of Birth
_____	_____	_____	_____/_____/_____

Birth Weight:	Hospital of Birth	City of Birth	County of Birth
_____ lbs. _____oz.	_____	_____	_____

Male ❑ Female ❑

RISK ASSESSMENT FOR MOM AT BIRTH OF BABY:

	True	Unknown
Heart Problems	❑	❑
Diabetes/Gestational diabetes	❑	❑
High Blood pressure	❑	❑
Sexually transmitted diseases	❑	❑
Multiple pregnancy	❑	❑
Mother smoked/suspected	❑	❑
Alcohol use/suspected	❑	❑
Drug use (incl. prescription)/suspected	❑	❑
Mother uses smokeless tobacco	❑	❑
Does not use seat belts	❑	❑
Other household members smokes	❑	❑
Other household member abuses alcohol	❑	❑
Homeless	❑	❑
Migrant	❑	❑
Does not read or speak English	❑	❑
Not enough money to meet basic needs	❑	❑
No plan to pay for delivery	❑	❑
Has insufficient support network	❑	❑
Is new to the community	❑	❑
Is geographically isolated	❑	❑
Has unsupportive or no family	❑	❑
Other children not immunized	❑	❑
Other children without medical home	❑	❑
Lack of knowledge or fear of parentiing	❑	❑
Age (under 19 or over 35)	❑	❑

RISK ASSESSMENT FOR MOM AT BIRTH OF BABY:

	Risk	True	History	Unknown
Other children under 2	❑	❑	❑	❑
Has no transportation	❑	❑	❑	❑
Is victim of family violence	❑	❑	❑	❑
Other _____	❑	❑	❑	❑

INSURANCE STATUS AT BIRTH OF BABY:

Private Insurance: (Choose One)	Baby	Mom
Has Insurance	❑	❑
No Insurance	❑	❑
Unknown	❑	❑

AHCCCS Status at Birth of Baby: (Choose One)	Baby	Mom
Enrolled in AHCCCS	❑	❑
Applied, waiting	❑	❑
Will apply	❑	❑
Denied	❑	❑
Does not want to apply	❑	❑
Unknown	❑	❑
Other	❑	❑

MARITAL STATUS: (Choose one)

Divorced	❑
Married	❑
Never Married	❑
Separated	❑
Widowed	❑
Living Together	❑
Unknown	❑
Other	❑

PRENATAL CARE INFORMATION:

_____
Health Plan/HMO/Insurance

_____
Date of First Prenatal Visit

_____
Number of Health Care Provider Prenatal Visits

REMINDER:

Update and submit a Family Immunization Roster for appropriate children in the household. If the only child in the household under four is the index child, do NOT submit a Family Immunization Roster.

QUESTIONS:

Family planning goal identified?	Yes ❑	No ❑	Unknown ❑
Was Karebook given?	Yes ❑	No ❑	Unknown ❑
Did mother begin breastfeeding the baby?	Yes ❑	No ❑	Unknown ❑
Is mother currently breastfeeding?	Yes ❑	No ❑	Unknown ❑

Health Care and Aging Studies Branch
Division of Adult and Community Health
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

I.3.3

Health-Related Quality-of-Life Measure (HRQOL-14)

The 4-item set of health-related quality-of-life questions (HRQOL-4) below has been in continuous use in the state-based Behavioral Risk Factor Surveillance System (BRFSS) since January, 1993 (See www.cdc.gov/nccdphp/brfss/). As of the end of 1999, over 800,000 adults aged 18 and older have responded to these core BRFSS questions. Beginning in 2000, the HRQOL-4 are also asked in the National Health and Examination Survey (NHANES) for persons aged 12 and older. A related 10-item Quality-of-Life (QOL) module has also been available for optional use in the BRFSS since January 1995. When used together, the HRQOL-4 and the supplemental 10-item module form the expanded HRQOL-14 set of questions that many states and communities are now using in their surveys, providing a large public-domain source of HRQOL population data.

The CDC HRQOL-14 questions have been validated in several studies, including ones that have cross-validated the questions with the widely-used Rand Corporation's Medical Outcomes Study Short-Form 36 (SF-36). Results to date indicate that the HRQOL-14 questions, in spite of their brevity, predict short-term mortality and hospital utilization and have reasonably good criterion validity with respect to the SF-36 in both healthy and disabled populations. The BRFSS QOL questions significantly extend the utility of the BRFSS, now administered and used by all 50 states and the District of Columbia.

The interview will only take a short time, and all the information obtained in this study will be confidential.

Section 1: Health Status

1. Would you say that in general your health is: (33)

Please Read		
a. Excellent		1
b. Very good		2
c. Good		3
d. Fair		4
or		
e. Poor		5
Do not read these responses	Don't know/Not sure	7
	Refused	9

2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? (34-35)

a.	Number of days	_ _
b.	None	8 8
	Don't know/Not sure	7 7
	Refused	9 9

3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? (36-37)

a.	Number of days	_ _
b.	None **If Q. 2 also "None," skip next question**	8 8
	Don't know/Not sure	7 7
	Refused	9 9

4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? (38-39)

a.	Number of days	_ _
b.	None	8 8
	Don't know/Not sure	7 7
	Refused	9 9

Supplemental Quality-of-Life Module

These next questions are about physical, mental, or emotional problems or limitations you may have in your daily life.

1. Are you LIMITED in any way in any activities because of any impairment or health problem?

a.	Yes	1
b.	No **Go to Q. 6**	2
	Don't know/Not sure **Go to Q. 6**	7
	Refused **Go to Q. 6**	9

2. What is the MAJOR impairment or health problem that limits your activities?

Do Not Read. Code Only One Category.

a.	Arthritis/rheumatism	0 1
b.	Back or neck problem	0 2
c.	Fractures, bone/joint injury	0 3
d.	Walking problem	0 4
e.	Lung/breathing problem	0 5
f.	Hearing problem	0 6
g.	Eye/vision problem	0 7
h.	Heart problem	0 8
i.	Stroke problem	0 9
j.	Hypertension/high blood pressure	1 0
k.	Diabetes	1 1
l.	Cancer	1 2
m.	Depression/anxiety/emotional problem	1 3
n.	Other impairment/problem	1 4
	Don't know/Not sure	7 7
	Refused	9 9

3. For HOW LONG have your activities been limited because of your major impairment or health problem?

Do Not Read. Code using respondent's unit of time.

a.	Days	1 _ _
b.	Weeks	2 _ _
c.	Months	3 _ _
d.	Years	4 _ _
	Don't know/Not sure	7 7 7
	Refused	9 9 9

4. Because of any impairment or health problem, do you need the help of other persons with your PERSONAL CARE needs, such as eating, bathing, dressing, or getting around the house?

a.	Yes	1
b.	No	2
	Don't know/Not sure	7
	Refused	9

5. Because of any impairment or health problem, do you need the help of other persons in handling your ROUTINE needs, such as everyday household chores, doing necessary business, shopping, or getting around for other purposes?

a.	Yes	1
b.	No	2
	Don't know/Not sure	7
	Refused	9

6. During the past 30 days, for about how many days did PAIN make it hard for you to do your usual activities, such as self-care, work, or recreation?

a.	Number of days	_ _
b.	None	8 8
	Don't know/Not sure	7 7
	Refused	9 9

7. During the past 30 days, for about how many days have you felt SAD, BLUE, or DEPRESSED?

a.	Number of days	_ _
b.	None	8 8
	Don't know/Not sure	7 7
	Refused	9 9

8. During the past 30 days, for about how many days have you felt WORRIED, TENSE, or ANXIOUS?

a.	Number of days	_ _
b.	None	8 8
	Don't know/Not sure	7 7
	Refused	9 9

9. During the past 30 days, for about how many days have you felt you did NOT get ENOUGH REST or SLEEP?

a.	Number of days	_ _
b.	None	8 8
	Don't know/Not sure	7 7
	Refused	9 9

10. During the past 30 days, for about how many days have you felt VERY HEALTHY AND FULL OF ENERGY?

a.	Number of days	_ _
b.	None	8 8
	Don't know/Not sure	7 7
	Refused	9 9

END

QOLMOD.00Q

The MOS 36-ITEM Short-Form Health Survey (SF-36)

I.3.3

INSTRUCTIONS: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is: **(circle one)**

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

2. Compared to one year ago, how would you rate your health in general now:

Much better than one year ago	1
Somewhat better now than one year ago	2
About the same as one year ago	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? Please rate according to the following scale:

	1=Yes, Not Limited A Lot	2=Yes, Limited A Little	3=No, Limited At All
A. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
B. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
C. Lifting or carrying groceries	1	2	3
D. Climbing several flights of stairs	1	2	3
E. Climbing one flight of stairs	1	2	3
F. Bending, kneeling, or stooping	1	2	3
G. Walking more than a mile	1	2	3
H. Walking several blocks	1	2	3
I. Walking one block	1	2	3
J. Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? Please rate according to the following:

	1=Yes	2=No
A. Cut down on the amount of time you spent on work or other activities	1	2
B. Accomplished less than you would like	1	2
C. Were limited in the kind of work or other activities	1	2
D. Had difficulty performing the work or other activities (for example, it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? Please rate according to the following

	1=Yes	2=No
A. Cut down the amount of time you spent on work or other activities	1	2
B. Accomplished less than you would like	1	2
C. Didn't do work or other activities as carefully as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

Not at all 1
Slightly 2
Moderately 3
Quite a bit 4
Extremely 5

7. How much bodily pain have you had during the past 4 weeks?

None 1
Very mild 2
Mild 3
Moderate 4
Severe 5
Very severe 6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

Not at all 1
A little bit 2
Moderately 3
Quite a bit 4
Extremely 5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.
How much of the time during the past 4 weeks. Please rate according to the following:

	1=All of the Time	2=Most of the Time	3= A Good Bit if the Time	4=Some of the Time	5=A Little of the Time	6=None of the Time
A. Did you feel full of pep?	1	2	3	4	5	6
B. Have you been a very nervous person?	1	2	3	4	5	6
C. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
D. Have you felt calm and peaceful?	1	2	3	4	5	6
E. Did you have a lot of energy?	1	2	3	4	5	6
F. Have you felt downhearted and blue?	1	2	3	4	5	6
G. Did you feel worn out?	1	2	3	4	5	6
H. Have you been a happy person?	1	2	3	4	5	6
I. Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time	1
Most of the time	2
Some of the time	3
A little of the time	4
None of the time	5

11. How TRUE or FALSE is each of the following statements for you?

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
J. I seem to get sick a little easier than other people	1	2	3	4	5
K. I am as healthy as anybody I know	1	2	3	4	5
L. I expect my health to get worse	1	2	3	4	5
M. My health is excellent	1	2	3	4	5

Latino Health Access
Santa Ana, CA

I.3.3

Team Plan Provider*

Provider: _____ **Chart #:** _____ **Date TPF was received:**_____

Name: _____

Gender/Sex: Male _____ **Female** _____ **Height:**_____ **Age :**_____

EXAMINATION DATE						
1. Ideal Weight: _____ Actual Weight: _____						
2. Blood Pressure (less than 140/90)						
BLOOD TEST						
3. Fasting Glucose: (70-120)						
4. Hemoglobin Alc (4.0-6.0)						
5. Cholesterol (less than 200)						
6. LDL/HDL						
7. Triglycerides (30-200)						
8. Creatinin (.7-1.5)						
URINE TESTS						
9. Microprotein/Protein						
10. Glucose (0)						
11. Blood (0)						
12. Ketones/Others (0)						
GENERAL RECOMMENDATIONS						
RESULTS DATE:						
Electrocardiogram						
Podiatrist						
Ophthalmologist						
Urologist						
Nephrologist						
Dentist						
Other						

** Form is available in Spanish*

NUTRITIONIST RECOMMENDATIONS:

Appointment Date: _____ **Kept Appointment:** _____ **Did not keep:** _____
Total calories recommended per day: _____
Nutritionist Name: _____
Signature: _____

Exchange	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Bread						
Meat						
Fruit						
Vegetables						
Milk						

EXERCISING RECOMMENDATIONS:

_____ Walk
_____ Low-impact aerobics
_____ Increase day to day
_____ Other activities (dancing, swimming, gardenwork)

GLUCOSE MONITORING: GLUCOMETER USE FOR GLUCOSE MEASURING

Glucometer: Yes _____ No _____
_____ First thing in the morning:
_____ 1/2 hour before dinner: _____ At bed time:
_____ 1 hour after the biggest meal:
_____ How many times per week?

MEDICATIONS RECOMMENDATIONS:

Date	Name	Dosage	Purpose

**** In case of emergency call 911 or go to the nearest emergency room ****

If you use insulin and your glucose lowers too much with the recommended dosage, you should reduce the amount of insulin you inject in _____ units and follow the instructions you were given in case of hypoglycemia.

Other notes: _____
_____

Doctor's Name: _____ **Signature:** _____

Latino Health Access
Santa Ana, CA

I.3.3

Record of Glucose Level, Weight, and Blood Pressure*

Name: _____
Chart #: _____
Comm. Clinic: _____
Group: _____
Day: _____

Height: _____

Module #	Date	Glucose Level	Weight	Time of Last Meal	Blood Pressure
Module 1					
Module 2					
Module 3					
Module 4					
Module 5					
Module 6					
Module 7					
Module 8					
Module 9					
Module 10					
Module 11					
Module 12					

Comments:

_____
_____
_____
_____
_____
_____
_____

** Form is available in Spanish*

Latino Health Access
Santa Ana, CA
Conociendo Nuestra Comunidad

I.3.3

Diabetes Control Program
Diabetic Retinopathy Evaluation
General Evaluation Form*

Date: _____
Name: _____
Date of Birth: _____/_____/_____
Phone: (_____) _____ Provider: _____

1. How long ago were you diagnosed with diabetes? _____ years ago
2. Are you on medication to treat your diabetes? Yes _____ No _____
2a. If Yes, what type of medication? Insulin _____ Pills _____
2b. Do you watch your diet? Yes _____ No _____
2c. Do you exercise regularly? Yes _____ No _____
3. Have you experienced any serious complication due to your diabetes? Yes _____ No _____
3a. If Yes, please state what type of complication? _____
4. Have you attended diabetes classes? Yes _____ No _____
4a. If Yes, in what year? Year _____
5. Have you ever been diagnosed with an eye condition? Yes _____ No _____
6. Please state what type of eye problem you were diagnosed with:
_____
7. Have your eyes been checked for any problems linked to your diabetes? Yes _____ No _____
8. Aside from your diabetes, do you suffer from:
8a. High blood pressure? Yes _____ No _____
8b. High cholesterol levels? Yes _____ No _____
8c. Overweight? Yes _____ No _____
9. Blood pressure: _____
10. Glucose level: _____ Time last meal was eaten: _____

Provider Comments: _____
_____
_____
_____

Signature: _____ **Date:** _____

** Form is available in Spanish*