

# MIECHV Adult Health Form

Timeframe:  Intake  Update

♦Home Visitor: \_\_\_\_\_

♦Agency ID: \_\_\_\_\_

♦Date Completed: \_\_\_\_\_

Participant ID#: \_\_\_\_\_

♦Time spent on form: \_\_\_\_\_ (min.)

**Completed at intake and every 6 months with primary caregivers who are fathers, grandparents or foster parents.**

♦Caregiver's First Name: \_\_\_\_\_

♦Caregiver's Last Name: \_\_\_\_\_

*In order to provide you and your family with the most appropriate care and services, I'm going to ask you some questions about your health history. It can be helpful to have a relationship with a medical provider who knows our history and can meet our medical needs. People refer to this as a medical home or a primary health care provider. Do you have a...*

♦Primary health care provider:

Dentist:

Yes Name: \_\_\_\_\_

Yes Name: \_\_\_\_\_

No Reason: \_\_\_\_\_

No Reason: \_\_\_\_\_

*Having health insurance can be helpful when accessing medical care. What is your...*

♦Health insurance status:

Medicaid  Medicare  SCHIP/CHIP  Tri-Care  CHAMPVA  Private

Other \_\_\_\_\_  None → Reason no insurance: \_\_\_\_\_

♦In the past 6 months, used emergency services (ER) for self:

No  Yes → Number of times: \_\_\_\_\_

Date of visit: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Date of visit: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

## HEALTH HISTORY

Any current acute or chronic medical conditions:

No  Yes → Describe: \_\_\_\_\_

## SUBSTANCE USE

♦ Tobacco product use:  Smoking cigarettes ↓  Chewing  Vaping  None

# cigarettes/day now: \_\_\_\_\_ # cigarettes/day before caring for index child: \_\_\_\_\_

Drink alcohol: (in past 6 months)

No  Yes → # drinks/day now: \_\_\_\_\_ # drinks/day before caring for index child: \_\_\_\_\_

Concerned about drinking: (self or anyone else)

No  Yes → Alcohol treatment plan:  No  Yes → Describe plan: \_\_\_\_\_

Drug use: (current or previous)

No

Yes, in the past →  Marijuana  Meth  Prescription drugs  Other \_\_\_\_\_

Yes, using currently →  Marijuana  Meth  Prescription drugs  Other \_\_\_\_\_

*If yes:* Drug treatment plan:  No

Yes → Describe plan: \_\_\_\_\_

## NOTES

Next Adult Health Form due:

06/2015

♦ Required Information ♦