Tell Us About Yourself

HEALTHY BEHAVIORS SURVEY

Florida HEALTH

For each statement, check the answer that is right for you.

1. I walk, run or exercise. ☐ Yes ☐ No
2. I drink more than 5 glasses of water every day. ☐ Yes ☐ No
3. I get enough sleep to feel rested. ☐ Yes ☐ No
4. I use a seat belt every time I get in a car. ☐ Yes ☐ No
5. I take my medicine as prescribed. ☐ Yes ☐ No ☐ Does not apply
6. I clean my teeth every day. ☐ Yes ☐ No
7. I keep track of when I get my period. ☐ Yes ☐ No ☐ Does not apply
8. I take vitamins or folic acid every day. ☐ Yes ☐ No
9. I eat 5 servings of fruits and vegetables a day. ☐ Yes ☐ No
10. I have healthy ways to reduce my stress level. ☐ Yes ☐ No
11. I have a doctor/nurse that I can see when needed ☐ Yes ☐ No
12. I have been tested for sexually transmitted diseases ☐ Yes ☐ No
13. I get my health advice from:
    ☐ family ☐ friends ☐ books ☐ doctor/nurse ☐ internet ☐ other_____
14. I see myself as:
    ☐ too fat ☐ too thin ☐ just fine as I am
15. Sometimes I have cravings for, and I eat:
    ☐ dirt/clay ☐ ashes ☐ sweets ☐ starch ☐ salty foods ☐ ice ☐ (other) _____
16. I have problems with my mouth such as:
    ☐ bleeding gums ☐ sores in my mouth ☐ toothaches ☐ no problems
17. I douche:
    ☐ once a week ☐ after sex ☐ after my period ☐ never
18. I take these medicines or herbal remedies:
    ☐ cold pills ☐ diet pills ☐ pain pills ☐ laxatives ☐ herbal teas/pills
19. I would like to have another baby in:
    ☐ 1-2 yrs. ☐ 3-4 yrs. ☐ 4 yrs. or more ☐ never ☐ whenever it happens
20. To keep from getting pregnant, I plan to:
    ☐ use pills ☐ use shots ☐ have tubes tied ☐ use condoms & foam ☐ other _____

Thank you for completing this form.
Your information will be kept confidential.

Today's Date: _____

Name: _____

ID#: _____

Date of Birth: _____

Tell Us About Yourself

QUESTIONNAIRE

FLORIDA DEPARTMENT OF HEALTH

Please answer these questions to help us understand some of the concerns in your life. For each question, check the answer that is right for you or write a short answer. Since this information is very personal to you, this form will become part of your medical record and will be treated with the same privacy. If you choose not to complete the form, you will still be able to receive services.

1. Check any of the statements that apply to you.

   ☐ I am single. ☐ I am married. ☐ I am separated.
   ☐ I have been divorced. ☐ I have been widowed. ☐ I am living with somebody.

2. What is the highest grade you finished in school? _____

3. Do you need help to finish school? ..... ☐ Yes ☐ No

4. What job(s) do you have? _____

5. Do you need help getting job training? ..... ☐ Yes ☐ No

6. Do you need help getting a job? ..... ☐ Yes ☐ No

7. Do you need help getting clothes? ..... ☐ Yes ☐ No

8. Do you need help getting childcare? ..... ☐ Yes ☐ No

9. Is there other help you need? ..... ☐ Yes ☐ No

   If yes, please write the type of help you need: _____

   _____

10. Put a check beside all of the things that have happened to you in the past year:

    ☐ I divorced. ☐ I moved. ☐ I have less money coming in.
    ☐ I lost my job/or changed jobs. ☐ I married. ☐ I lost someone close to me.
    ☐ I had legal problems. ☐ I became pregnant. ☐ I have a new boyfriend/girlfriend.

11. How have you been feeling lately? Check those that apply to you:

    ☐ I often feel happy. ☐ I often feel sad. ☐ I often feel angry.
    ☐ I often feel weak and tired. ☐ I often feel confused. ☐ I often feel afraid.
    ☐ I often feel OK. ☐ I often feel hopeless. ☐ I often feel alone.
    ☐ I often feel homesick. ☐ I often feel stressed. ☐ I often feel worried.
    ☐ I often feel _____

12. Sometimes I feel I am treated differently than others because: _____

13. Do you think your parents or the people who raised you were mean to you when you were a child? ..... ☐ Yes ☐ No

14. If yes, how were they mean?:

    ☐ I was yelled at. ☐ I was sexually abused. ☐ I was neglected.
    ☐ I was beaten. ☐ I was put down. ☐ I witnessed violence.
    ☐ Other _____

Today's Date: _____

Name: _____

ID#: _____

Date of Birth: _____

15. Do you do any of the following when you get angry? Check all the answers that apply to you:

- ☐ I leave.
- ☐ I yell.
- ☐ I keep my feelings inside.
- ☐ I cry.
- ☐ I hit things.
- ☐ I hit people.
- ☐ I throw things.
- ☐ I do other things. *(Write your answer here)* _____

16. Have you ever been made to have sex when you did not want to? ..... ☐ Yes ☐ No

17. Do you feel unsafe in your home? ..... ☐ Yes ☐ No

18. Are you in a relationship in which you are being hurt or threatened emotionally or physically? ..... ☐ Yes ☐ No

19. Have you ever had a problem from not eating enough, or eating too much? ..... ☐ Yes ☐ No

20. Do you have trouble falling asleep or staying asleep? ..... ☐ Yes ☐ No

21. Have you lost interest in things you used to enjoy? ..... ☐ Yes ☐ No

22. Have you ever felt hopeless and thought about hurting yourself or someone else? ... ☐ Yes ☐ No
    Are you feeling this way now? ..... ☐ Yes ☐ No

23. Have you ever received help for any mental or emotional problems? ..... ☐ Yes ☐ No
    If yes, please write the type of problem here: _____

24. Do you smoke, chew or dip tobacco? ..... ☐ Yes ☐ No

25. Does anyone smoke cigarettes, cigars, or a pipe in your home or car? ..... ☐ Yes ☐ No

26. Have either of your parents ever had problems with drugs or alcohol? ..... ☐ Yes ☐ No

27. Does your partner or someone close to you have a problem with drugs or alcohol? ☐ Yes ☐ No

28. Have you ever used drugs or alcohol? ..... ☐ Yes ☐ No

29. If you drink or use drugs now, check the answers that apply to you:

- ☐ I feel I should cut down on my drinking or drug use.
- ☐ People have criticized my drinking or drug use.
- ☐ I have had a drink first thing in the morning to get rid of a hangover.
- ☐ I have tried to stop drinking or using drugs.
- ☐ I feel OK about my drinking or drug use.

30. Who do you talk with when you have a problem? Check those that apply to you:

- ☐ Spouse/Partner
- ☐ Parent/Grandparent
- ☐ Godparent
- ☐ Other family
- ☐ Religious advisor
- ☐ Friend
- ☐ Counselor
- ☐ No one

31. Do you have a problem you need to talk with someone about? ..... ☐ Yes ☐ No

32. Is there anything else you would like to tell us about yourself to help us care for you better? *If so, write it here:*

_____

_____

If you are pregnant, please complete questions 33 through 38.
If you are not pregnant, thank you for completing this questionnaire.

Name: _____

ID#: _____

Date of Birth: _____

If you are pregnant, please complete questions 33 through 38.

33. How do you feel about this pregnancy? Write your feelings here:

_____

34. Do you plan to breastfeed your baby ..... ☐ Yes ☐ No

35. Do you have questions about keeping the baby? ..... ☐ Yes ☐ No

36. Who knows that you are pregnant?

☐ The baby's father ☐ My family ☐ My friends
☐ No one knows I am pregnant ☐ A social agency

37. Are you happy with your relationship with the baby's father? ..... ☐ Yes ☐ No

38. Would you like help learning to care for your baby or older children? ..... ☐ Yes ☐ No

Thank you for completing this form. Your information will be kept confidential.

FOR STAFF TO COMPLETE

☐ No referral necessary.

☐ Referral(s) made to: _____

_____

_____

☐ Referral declined.

☐ See Progress Notes.

☐ DH 3202 (DV Screening & Assessment Form) completed for "yes" responses to # 17 and / or # 18.

_____
Signature of Staff Member Reviewing / Title

_____
Date

_____
Signature of Supervisor Reviewing, if required / Title

_____
Date

Name: _____

ID#: _____

Date of Birth: _____