JUST HEALTH PATIENT REPORT

Name:	Bob M Jones	Date of Birth:	4/21/2000	Age:	17	Grade:	12	ID Number:	1234567
Gender:	Femal	Sexual Orientation:	Gay or Lesbian	Sex at Birth:	Female	Preferred Pronoun:	No pronouns, just my n		
Relationship Status:	It's complicated	Race:	American Indian or Alaskan Nat	Hispanic/Latino(a):	No				

CRAFFT

0	0-1 Negative ●	
	2-6 Positive	

PHQ-9

11	5-9 Mild Depression	15-19 Moderately Severe Depression	
	10-14 Moderate Depression ●	20-27 Severe Depression	

GAD-7

12	0-4 No Concern	10-14 Moderate Concern ●
	5-9 Mild Concern	15-21 Severe Concern

Check boxes to highlight responses: ◎ AUTO-SKIPPED ◎ UNANSWERED ◎ NO CONCERN ◎ NEEDS ATTENTION ◎ RISK FACTOR

PATIENT'S RESPONSES

Home / School	Lives	Lives with: Father, Foster parent	Has someone they can talk to: No	They talk to
	Problems at home: No	What home problems	Problems at school: No	What school problems

Provider Review:

Health Behaviors	Participate in 1 hour of physical activity per day: No	More than 2 hours per day watching TV / Video: No	5 or more servins of fruits and vegetables: Yes	More than 8 hours of sleep per night: Yes
	Dental in last 6 months: Yes	Have tooth pain: Yes	Vaccinated for HPV: : No	

Provider Review:

Safety / Injuries	Always wears a seatbelt: No	Always wears a helmet: Yes	Text, talk, surf Internet while driving: Always	Using hands-free device while driving: Rarely
	Feel afraid, threatened, hurt: Yes	Physically, sexually, emotionally abused: Yes	Hit by boyfriend / girlfriend	Carry a weapon for protection: No
	Foster care, group home or homeless	Spent a night in jail or detention center: Yes		

Provider Review:

Feelings / Well-Being GAD-7, PHQ-9	Worry or feel like something bad will happen: Yes	Tense, stressed out, trouble relaxing: No	Feeling nervous, anxious or on edge: Several Days	Cannot stop or control worrying: Not At All
	Worrying too much: Nearly Everyday	Trouble relaxing: Nearly Everyday	So restless it's hard to sit still: Several Days	Easily annoyed or irritable: Nearly Everyday
	Feeling afraid / something awful might happen: Several Days	Difficulties from anxiety: Somewhat difficult	Little interest or pleasure in doing things: Not At All	Feeling down, depressed, irritable or hopeless: Nearly Everyday
	Trouble sleeping, or sleeping	Poor appetite, weight loss, overeating: Several Days	Tired or having low energy: Several Days	Feeling bad about themselves: More Than Half

too much: Several Days			The Days
Trouble concentrating on things: Nearly Everyday	Moving / speaking slowly (or opposite): Several Days	Thought better off dead, or hurt self: Not At All	Felt depressed / sad most days in past year: Yes
Problems making life hard: Somewhat difficult	Purposefully hurt themselves: Yes	Thought about ending life in last month: Yes	Has ever tried to commit suicide: No

Provider Review:

Relationships / Sexual Activity	Has had sex: Yes	Thinking about having sex:	Do you think you are you attracted to: Women	How long has it been since you started having sex: 3-5 years
	How many sex partners have you had in the last year:2-5	Has sex with: Men, Transgender Women	Kinds of sex: Receptive anal sex (partner's penis in your anus), Insertive anal sex (your penis in partner's anus), Give oral sex (your mouth on partner's genitals)	Do your sex partner(s) have sex with both men and women: Yes
	Do you know or think your partner may have had sex with someone other than you, while you were in a relationship with them: Unsure	Do you think you or your partner could have a sexually transmitted disease (STD) like gonorrhea, chlamydia, HIV, etc.:Yes	Are you using a method to prevent pregnancy:Yes	Which types of birth control: Condoms, Patch (Ortho Evra), Pulling out, IUD
	Have you ever been pregnant or gotten someone pregnant:	Have you been tested for gonorrhea or chlamydia in the past year:No	Have you ever been tested for HIV:Yes	Were you ever told you have a sexually transmitted disease (STD) like gonorrhea, chlamydia, HIV, etc.:Unsure
	Which STDs were you told you had:	Do you discuss past sexual experiences with sex partner(s): Never	Have you ever had sex with an HIV positive person: Yes	Have you ever sexted or has anyone sexted you (texted, emailed, or posted online sexually suggestive pictures): No

	Have you had sex with people you met online or through an app (tinder, grindr, forums, dating websites, etc.): Yes	Have you ever had a sexual encounter you'd like to talk about:	Do you use drugs or alcohol before, during, or after sex: Always	Have you or your sex partner(s) ever injected (shot up) drugs (for example, morphine, heroin, cocaine or meth):

Provider Review:

Health behaviors / Substance Use CRAFFT	Used tobacco in last 12 months: Yes	Ridden in car with someone who was impaired	Ever drank alcohol: No	Ever used Marijuana
	Ever taken other drugs: No	Use alcohol / drugs to relax or fit in	Use alcohol / drugs alone	Forget things while using alcohol / drugs
	Family / friends say to cut down	In trouble while using alcohol / drugs		

Provider Review:

Development / Future Plans	Concerns / question about body	Do you like yourself?: 1	Future goals: 7~WO $K/Yg_I]|?{V	Contact info Email: T-rMZ Cell: h Friend's #: H7g"jfwmz[gVlLE*urSsw6

Provider Review:

SEXUAL HEALTH CLINICAL GUIDANCE

Recommended Screen(s)
Urogenital CT and GC (test today)
Rectal CT and GC: rectal swab (test today)
Pharyngeal GC: pharyngeal swab (test today)

Counseling Messages
Patient has indicated that they have had sex with a partner they met online or through an app. Encourage the use of safe sex practices and underscore the importance of such practices.
Patient has indicated they have used drugs or alcohol before, during, or after sex. Encourage the use of safe sex practices and discuss why they use these substances in conjunction with sex, or other sexual activity.
Provide counselling on the importance of condom use for receptive anal sex.
Provide counselling on the importance of condom use for insertive anal sex.
Provide counselling on the importance of condom use for giving oral sex.

PROVIDER ACTIONS

- [x] Made Referral
- [ ] Provided Treatment
- [x] Offered Counseling
- [ ] No Concerns

SIGNATURE

Signature of Reviewer 

Reviewed with Patient X **Date** 10/16/2017