Connecticut Department of Mental Health and Addiction Services

HEALTH ASSESSMENT FORM - DDaP

PROVIDER CLIENT ID: _____

CLIENT NAME: _____

DATE FORM COMPLETED: _____ / _____ / _____

BMI (BODY MASS INDEX): **(Enter 10.0 - 100.0)** ☐

BLOOD PRESSURE: **SYSTOLIC:** **(Enter 70 - 200)** ☐

DIASTOLIC: **(Enter 30 - 130)** ☐

WHAT TOBACCO/NICOTINE CESSATION RELATED SERVICES/ACTIVITIES WERE RECEIVED BY THE PERSON IN THE PAST 90 DAYS? ***(check all that apply)***	
☐ **GROUP INTERVENTION**	☐ **INDIVIDUAL INTERVENTION**
☐ **REWARDS TO QUIT PROGRAM**	☐ **NICOTINE REPLACEMENT THERAPY (GUM, LOZENGES, PATCH, ETC.)**
☐ **EDUCATIONAL MATERIALS**	☐ **REFUSED**
☐ **NONE**	☐ **N/A**

Note: If Refused, None or N/A is selected, no other services or activities can be selected.