Whole Child Assessment for Ages 0-6 Months

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	Child's Name (first & last)	Date of Birth	□ Female	Today's Date	In Child/Daycare?	
			□ Male		□ Yes	□ No
	Person Completing Form	□ Biological Pare	ent			
	□ Relative	□ Step Parent				
	□ Friend	□ Adopted Paren	t			
	□ Other (specify)	□ Foster Parent				

chil ans	ase answer all the questions on this form as best you can. It will be healthy. You may skip any question if you do not know a wer. You may add comments to explain your answers. We will ess there's concern that your child is being hurt.	n answer	or do not want to	1 ,	Clinic Use Only:
1	Do you breastfeed your baby?	Yes	Unsure	No	Nutrition
2	Do you take a multivitamin, prenatal vitamin or folic acid?	Yes	Unsure	No	
3	Is your baby enrolled in WIC?	Yes	Unsure	No	
4	In the past month , did you run out of formula for your baby?	No	Breastfeed	Yes	
5	In the past year, did you worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often	
6	Are you concerned about your baby's weight?	No	Unsure	Yes	Physical
7	Does your baby watch any TV?	No	Unsure	Yes	Activity
8	Do you always put your baby to sleep on his/her back?	Yes	Unsure	No	Sleep
9	Does your home have a working smoke detector?	Yes	Unsure	No	Safety
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	Unsure	No	·
11	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	One floor	No	
12	Does your home have cleaning supplies, medicines and matches locked away?	Yes	Unsure	No	
13	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by the phone?	Yes	Unsure	No	
14	Do you always stay with your baby when s/he is in the bathtub?	Yes	Unsure	No	
15	Do you always place your baby in a rear facing car seat in the back seat?	Yes	Unsure	No	
16	Is the car seat you use the right one for the age and size of your baby?	Yes	Unsure	No	
17	Does your baby spend time in a home where a gun is kept?	No	Unsure	Yes	
18	In the past year, have you felt safe in your relationship?	Yes	No partner	No	
19	In the past year, have you and your partner fought a lot?	No	No partner	Yes	
20	Has your baby ever witnessed adults in the home pushing, hitting, kicking or physically threatening each other?	No	Unsure	Yes	
21	Has your baby ever lived with a parent or other adult who shook or threw the baby?	No	Unsure	Yes	
22	Has your baby ever lived away from home for more than a month?	No	Unsure	Yes	
23	Do you give your baby a bottle with anything except formula, breast milk or water?	No	Unsure	Yes	Dental
24	Do you feel your baby is difficult to take care of?	Never	Sometimes	Often	Parenting
25	Are you currently living with a spouse or partner?	Yes	Unsure	No	Stress
26	Are your baby's parents separated, divorced, or not living together?	No	Unsure	Yes	

27	Did your baby ever live with anyone who went to prison, jail or other correctional facility?	No	U	nsure	Yes	
28	Do you have friends or family who help take care of your baby?	Often	Sor	netimes	Never	
29	Does your family look out for each other, feel close to each other and support each other?	Often	Sor	Sometimes		
30	Over the past 2 weeks , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	Mental Health
	A1. Little interest or pleasure in doing thingsA2. Feeling down, depressed, or hopeless	0	1	2	3	
	B1. Feeling nervous, anxious or on edge	0	1	2	3	Total Part A:
	B2. Not being able to stop or control worrying	0	1	2	3	Total Part B:
21		0	1	2	3	Total Part B:
31	Did your baby ever live with anyone who was depressed, mentally ill or suicidal?	No		nsure	Yes	
32	Does your baby spend time with anyone who smokes?	No	U	nsure	Yes	Substance
33	During the past three months, have you had more than 4 drinks containing alcohol in one day?	No	U	Unsure		Exposure
34	Did your baby ever live with anyone who had a problem with drugs or alcohol?	No	U	Unsure		
35	Has a family member or contact had tuberculosis disease?	No	U	nsure	Yes	Tuberculosis
36	Has a family member had a positive tuberculin skin test result?	No	U	nsure	Yes	Risk
37	Was your baby born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)?	No	U	nsure	Yes	
38	Has your baby traveled (had contact with resident populations) to a high-risk country for more than 1 week?	No	U	nsure	Yes	
39	Do you have a high school degree?	Yes	U	nsure	No	Other
40	Are you doing something to keep yourself (or your partner)	□ Ye	s, IUD or	implant		Questions
	from getting pregnant?	□ Ye	s, perman	ent (e.g. tubes	tied or	
			sectomy)			
				rth control		
			, pregnant			
		□ No, trying to get pregnant				
41	De van have any other succtions on a manne of the	□ No		nsure	Yes	
41	Do you have any other questions or concerns about your	INO		nsure	res	
	baby's health, development, or behavior?					

Clinic Use Only			Provided	Ordered	Comments
Screened	Counseled	Referred	Handout	Follow-up	
□ Nutrition					
□ Physical Activity					
□ Sleep					
□ Safety					
□ Dental Health					
□ Parenting Stress					
□ Mental Health					
□ Substances					
□ Tuberculosis					☐ Patient Declined WCA
□ Other					
PCP's Signature		Print	Name		Date

Whole Child Assessment for Ages 7-12 Months

	0				
Child's Name (first & last)	Date of Birth	□ Female	Today's Date	In Child/Daycare?	
		□ Male		□ Yes	□ No
Person Completing Form	□ Biological Pare	ent			
□ Relative	□ Step Parent				
□ Friend	□ Adopted Parent	t			
□ Other (specify)	□ Foster Parent				

child be healthy. You may skip any question if you do not know an answer or do not want to answer. You may add comments to explain your answers. We will keep this information confidential, unless there's concern that your child is being hurt.									
1	Do you breastfeed your baby?	Yes	Unsure	No	Only: Nutrition				
2	Do you take a multivitamin, prenatal vitamin or folic acid?	Yes	Unsure	No					
3	Does your baby drink or eat 3 servings of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or tofu?	Yes	Unsure	No					
4	Is your baby enrolled in WIC?	Yes	Unsure	No					
5	In the past month , did you run out of formula for your baby?	No	Breastfeed	Yes					
6	In the past year, did you worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often					
7	Are you concerned about your baby's weight?	No	Unsure	Yes	Physical				
8	Does your baby watch any TV?	No	Unsure	Yes	Activity				
9	Do you always put your baby to sleep on his/her back?	Yes	Unsure	No	Sleep				
10	Does your home have a working smoke detector?	Yes	Unsure	No	Safety				
11	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	Unsure	No					
12	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	One floor	No					
13	Does your home have cleaning supplies, medicines and matches locked away?	Yes	Unsure	No					
14	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by the phone?	Yes	Unsure	No					
15	Do you always stay with your child when s/he is in the bathtub?	Yes	Unsure	No					
16	Do you always place your child in a rear facing car seat in the back seat?	Yes	Unsure	No					
17	Is the car seat you use the right one for the age and size of your baby?	Yes	Unsure	No					
18	Does your baby spend time near a swimming pool, river, or lake?	No	Unsure	Yes					
19	Does your baby spend time in a home where a gun is kept?	No	Unsure	Yes					
20	In the past year, have you felt safe in your relationship?	Yes	No partner	No					
21	In the past year, have you and your partner fought a lot?	No	No partner	Yes					
22	Has your baby ever witnessed adults in the home pushing, hitting, kicking or physically threatening each other?	No	Unsure	Yes					
23	Has your baby ever lived with a parent or other adult who shook or threw the baby?	No	Unsure	Yes					
24	Has your baby ever lived away from home for more than a month?	No	Unsure	Yes					
25	Do you give your baby a bottle with anything except formula, breast milk or water?	No	Unsure	Yes	Dental				

26	Do you feel your baby is difficult to take care of?	Never	Soi	metimes	Often	Parenting
27	Are you currently living with a spouse or partner?	Yes	Ţ	Insure	No	Stress
28	Are your baby's parents separated, divorced, or not living together?	No	U	Insure	Yes	
29	Did your baby ever live with anyone who went to prison, jail or other correctional facility?	No	Ţ	Insure	Yes	
30	Do you have friends or family who help take care of your baby?	Often	Soi	metimes	Never	
31	Does your family look out for each other, feel close to each other and support each other?	Often		metimes	Never	
32	Over the past 2 weeks , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	Mental Health
	A1. Little interest or pleasure in doing things A2. Feeling down, depressed, or hopeless	0 0	1 1	2 2	3 3	Total Part A:
	B1. Feeling nervous, anxious or on edgeB2. Not being able to stop or control worrying	0	1	2	3	Tatal Dant D.
33	Did your baby ever live with anyone who was depressed,	0 No	1	Jnsure	3 Yes	Total Part B:
33	mentally ill or suicidal?	110		risuic	105	
34	Does your baby spend time with anyone who smokes?	No	Unsure		Yes	Substance
35	During the past three months, have you had more than 4	No	Unsure		Yes	Exposure
	drinks containing alcohol in one day?					
36	Did your baby ever live with anyone who had a problem with drugs or alcohol?	No	U	Insure	Yes	
37	Has a family member or contact had tuberculosis disease?	No	U	Insure	Yes	Tuberculosis
38	Has a family member had a positive tuberculin skin test result?	No	U	Insure	Yes	Risk
39	Was your baby born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)?	No	τ	Unsure		
40	Has your baby traveled (had contact with resident populations) to a high-risk country for more than 1 week?	No	Ţ	Unsure		
41	Do you have a high school degree?	Yes	U	Insure	No	Other
42	Are you doing something to keep yourself (or your partner) from getting pregnant?	 Yes, IUD or implant Yes, permanent (e.g. tubes vasectomy) Yes, other birth control No, pregnant No, trying to get pregnant No 		t	Questions	
43	Do you have any other questions or concerns about your baby's health, development, or behavior?	No	U	Insure	Yes	

Clinic Use Only			Provided	Ordered	Comments
Screened	Counseled	Referred	Handout	Follow-up	
□ Nutrition					
□ Physical Activity					
□ Sleep					
□ Safety					
□ Dental Health					
□ Parenting Stress					
□ Mental Health					
□ Substances					
□ Tuberculosis					□ Patient Declined WCA
□ Other					
PCP's Signature		F	rint Name		Date

Whole Child Assessment for Ages 1 – 2 Years

Child's Name (first & last)	Date of Birth	□ Female	Today's Date	In Child/Daycare?	
		□ Male		□ Yes	□ No
Person Completing Form	☐ Biological Pare	ent			
□ Relative	□ Step Parent				
□ Friend	□ Adopted Paren	t			
□ Other (specify)	☐ Foster Parent				

child be healthy. You may skip any question if you do not know an answer or do not want to inswer. You may add comments to explain your answers. We will keep this information confidential, unless there's concern that your child is being hurt.								
1	Do you breastfeed your child?	Yes	Unsure	No	Nutrition			
2	Do you take a multivitamin, prenatal vitamin or folic acid?	Yes	Unsure	No				
1	Does your child eat breakfast every day ?	Yes	Unsure	No				
ļ	Does your child drink or eat 3 servings of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or tofu?	Yes	Unsure	No				
	Does your child eat fruits and vegetables <u>at least two</u> times per day ?	Yes	Unsure	No				
i	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Unsure	Yes	-			
	Does your child drink <u>more than one</u> small cup (4 - 6 oz.) of juice per day ?	No	Unsure	Yes				
	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week ?	No	Unsure	Yes				
	Is your child enrolled in WIC?	Yes	Unsure	No				
0	In the past year, did you worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often				
1	Does your child play actively most days of the week?	Yes	Unsure	No	Physical			
2	Does your child watch TV or play video games?	No	Unsure	Yes	Activity			
3	Are you concerned about your child's weight?	No	Unsure	Yes				
4	Does your child have trouble falling asleep or staying asleep?	No	Unsure	Yes	Sleep			
5	Does your home have a working smoke detector?	Yes	Unsure	No	Safety			
6	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	Unsure	No				
7	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	One floor	No				
8	Does your home have cleaning supplies, medicines and matches locked away?	Yes	Unsure	No				
9	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by the phone?	Yes	Unsure	No				
0	Do you always stay with your child when s/he is in the bathtub?	Yes	Unsure	No				
1	Do you always place your child in a rear facing car seat in the back seat?	Yes	Unsure	No				
2	Is the car seat you use the right one for the age and size of your child?	Yes	Unsure	No				
3	Do you always check for children before backing your car out?	Yes	Unsure	No				

24	Does your child spend time near a swimming pool, river, or lake?	No	I	Unsure	Yes	
25	Does your child spend time in a home where a gun is kept?	No	1	Unsure	Yes	
26	Does your child always wear a helmet when riding a bike,	Yes		Doesn't	No	
	skateboard, or scooter?	100		ride	1,0	
27	In the past year, have you felt safe in your relationship?	Yes	No	partner	No	
28	In the past year, have you and your partner fought a lot?	No		partner	Yes	
29	Has your child ever witnessed adults in the home pushing,	No		Unsure	Yes	
	hitting, kicking or physically threatening each other?	110	•		103	
30	Has your child ever lived with a parent or other adult who pushed, kicked, physically hurt or threw something at the child?	No	1	Unsure	Yes	
31	Has your child ever lived away from home for more than a month?	No	ı	Unsure	Yes	
32	Do you help your child brush and floss her/his teeth daily?	Yes	Ţ	Unsure	No	Dental
33	Do you feel your child is difficult to take care of?	Never	1	metimes	Often	Parenting
34	Do you swear at or insult your child?	Never	So	metimes	Often	Stress
35	Do you need to hit/spank your child?	Never		metimes	Often	24000
36	Are you currently living with a spouse or partner?	Yes		Unsure	No	
37	Are your child's parents separated, divorced, or not living	No		Unsure	Yes	
	together?				Yes	
38	Did your child ever live with anyone who went to prison, jail or other correctional facility?	No	l	Unsure		
39	Do you have friends or family who help take care of your child?	Often	Sometimes		Never	
40	Does your family look out for each other, feel close to each other and support each other?	Often	Sometimes		Never	
41	Over the past 2 weeks, how often have you been bothered	Not at	Several	More than	Nearly	Mental
	by any of the following problems?	all	days	half the days	every day	Health
	A1. Little interest or pleasure in doing things	0	1	2	3	
	A2. Feeling down, depressed, or hopeless	0	1	2	3	Total Part A:
	B1. Feeling nervous, anxious or on edge	0	1	2	3	
	B2. Not being able to stop or control worrying	0	1	2	3	Total Part B:
42	Did your child ever live with anyone who was depressed,	No	Į į	Unsure	Yes	
	mentally ill or suicidal?					
43	Does your child spend time with anyone who smokes?	No		Unsure	Yes	Substance
44	During the past three months, have you had more than 4 drinks containing alcohol in one day?	No	1	Unsure	Yes	Exposure
45	Did your child ever live with anyone who had a problem with drugs or alcohol?	No	ı	Unsure	Yes	
46	Do you know or are you concerned that your child was ever					Sexual
1.0	touched, or asked to touch, an adult or someone at least 5	No	1	Unsure		Issues
	years older sexually?	1,0	Ulisuie		Yes	155005
47	Has a family member or contact had tuberculosis disease?	No	Unsure		Yes	Tuberculosis
48	Has a family member had a positive tuberculin skin test	No	Unsure		Yes	Risk
70	result?	110	Unsure		103	KISK
49	Was your child born in a high-risk country (countries other	No	Unsure		Yes	
+7	than the United States, Canada, Australia, New Zealand, or	110	'	Justic	108	
	Western and North European countries)?					
50	Has your child traveled (had contact with resident	No	1	Unsure	Yes	
	populations) to a high-risk country for more than 1 week?	110]		103	
	populations) to a mgn-risk country for more than I week!					

51	Do you have a high school degree?	Yes	Unsure	No	Other
52	Are you doing something to keep yourself (or your partner)		s, IUD or implant		Questions
	from getting pregnant?		s, permanent (e.g. tubes	tied or	
			sectomy)		
		□ Ye	s, other birth control		
			, pregnant		
		□ No	, trying to get pregnant		
		□ No)		
53	Do you have concerns about how your child speaks?	No	Unsure	Yes	
54	Do you have any other questions or concerns about your	No Unsure		Yes	
	child's health, development, or behavior?				

Clinic Use Only Screened	Counseled	Referred	Provided Handout	Ordered Follow-up	Comments
□ Nutrition					
□ Physical Activity					
□ Sleep					
□ Safety					
□ Dental Health					
□ Parenting Stress					
□ Mental Health					
□ Substances					
□ Sexual					□ Patient Declined WCA
□ Tuberculosis					
□ Other					
PCP's Signature		F	Print Name		Date

Whole Child Assessment for Ages 3 – 4 Years

				,	
Child's Name (first & last)	Date of Birth	□ Female	Today's Date	In Child/Daycare?	
		□ Male		⊓ Yes	⊓ No
Person Completing Form	□ Biological Pare	ent	L		
1 crossi completing 1 orin		2110			
□ Relative	□ Step Parent				
□ Friend	□ Adopted Paren	t			
□ Other (specify)	□ Foster Parent				

chile ansv	use answer all the questions on this form as best you can. It we delight be healthy. You may skip any question if you do not know of wer. You may add comments to explain your answers. We will sess there's concern that your child is being hurt.	an answer	or do not want to		Clinic Use Only:
1	Do you take a multivitamin, prenatal vitamin or folic acid?	Yes	Unsure	No	Nutrition
2	Does your child eat breakfast every day ?	Yes	Unsure	No	
3	Does your child drink or eat <u>3 servings</u> of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or tofu?	Yes	Unsure	No	
4	Does your child eat fruits and vegetables at least two times per day ?	Yes	Unsure	No	
5	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Unsure	Yes	
6	Does your child drink <u>more than one</u> small cup (4 - 6 oz.) of juice per day ?	No	Unsure	Yes	
7	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week ?	No	Unsure	Yes	
8	Is your child enrolled in WIC?	Yes	Unsure	No	
9	In the past year, did you worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often	
10	Does your child play actively most days of the week?	Yes	Unsure	No	Physical
11	Does your child watch TV or play video games <u>less than 2</u> hours per day ?	Yes	Unsure	No	Activity
12	Are you concerned about your child's weight?	No	Unsure	Yes	
13	Does your child have trouble falling asleep or staying asleep?	No	Unsure	Yes	Sleep
14	Does your home have a working smoke detector?	Yes	Unsure	No	Safety
15	Have you turned your water temperature down to lowwarm (less than 120 degrees)?	Yes	Unsure	No	
16	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	One floor	No	
17	Does your home have cleaning supplies, medicines and matches locked away?	Yes	Unsure	No	
18	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by the phone?	Yes	Unsure	No	
19	Do you always stay with your child when s/he is in the bathtub?	Yes	Unsure	No	
20	Do you always place your child in a forward facing car seat in the back seat?	Yes	Unsure	No	
21	Is the car seat you use the right one for the age and size of your child?	Yes	Unsure	No	
22	Do you always check for children before backing your car out?	Yes	Unsure	No	

23 Does your child spend time near a swimming pool, river, or lake?							
Does your child spend time in a home where a gun is kept? No Unsure Yes	23	* * * * * * * * * * * * * * * * * * * *	No	1	Unsure	Yes	
25 Does your child always wear a helmet when riding a bike, Yes Doesn't No ride ride	24		No	1	Unsure	Yes	
skateboard, or scooter? In the past year, have you felt safe in your relationship? In the past year, have you and your partner fought a lot? No No partner Yes Has your child ever witnessed adults in the home pushing, hitting, kicking or physically threatening each other; child? Has your child ever lived with a parent or other adult who pushed, kicked, physically hurst enting each other; child? Has your child ever lived with a parent or other adult who pushed, kicked, physically hurst enting each other; child? Has your child ever lived away from home for more than a month? I Do you help your child brush and floss her/his teeth daily? Yes Unsure No Dental Parenting 20 you need to hit/spank your child? Never Sometimes Often Never Sometimes Never No Unsure Yes Unsure No Unsure Yes Unsure No Unsure Yes Unsure No Unsure Yes Often No Unsure Yes Often No Unsure Yes No Unsure Yes No Unsure Yes No Unsure No Unsure Yes No Unsure Yes No Unsure Yes Unsure No Unsure Yes Unsure No Unsure Yes Unsure No Unsure Yes Unsure		· .					
26 In the past year, have you felt safe in your relationship? Ves No pantner No		, ,					
In the past year, have you and your partner fought a lot? No No partner Yes	26	·	Yes	No	o partner	No	
Has your child ever witnessed adults in the home pushing, hitting, kicking or physically threatening each other? Has your child ever lived with a parent or other adult who pushed, kicked, physically threatening each other? Has your child ever lived away from home for more than a month? Joy ou help your child brush and floss her/his teeth daily? Yes Unsure No Dental Do you field ever lived with a problem with drugs or alcohol? Do you nelp your child brush and floss her/his teeth daily? Yes Unsure No Dental Do you seed to hit/spank your child? Never Sometimes Often Of					_		
hitting, kicking or physically threatening each other? Has your child ever lived with a parent or other adult who pushed, kicked, physically hurt or threw something at the child? Has your child ever lived away from home for more than a month? Do you help your child brush and floss her/his teeth daily? Yes Unsure No Dental month? Do you feel your child is difficult to take care of? Never Sometimes Often Parenting Do you need to hit/spank your child? Never Sometimes Often Stress Are you currently living with a spouse or partner? Yes Unsure No Are your child's parents separated, divorced, or not living together? Did your child ever live with anyone who went to prison, jail or other correctional facility? Do you have friends or family who help take care of your child? Over the past 2 weeks, how often have you been bothered by any of the following problems? Al. Little interest or pleasure in doing things Al. Little interest or pleasure in doing things Al. Eiteling able to stop or control worrying Bl. Recling nervous, anxious or on edge Bl. Not being able to stop or control worrying Bl. Not being able to stop or control worrying Does your child spend time with anyone who was depressed, mentally ill or suicidal? Doy out child ever live with anyone who smokes? Does your child ever live with anyone who smokes? Does your child ever live with anyone who smokes? Does your child ever live with anyone who smokes? No Unsure Yes Substance Exposure Total Part A: Total Part B: Doy on how or are you concerned that your child was ever touched, or asked to touch, an adult or someone at least 5 years older sexually? Has a family member or contact had tuberculosis disease? No Unsure Yes Issues Least 5 years older sexually? Has a family member or contact had tuberculosis disease? No Unsure Yes Tuberculosis Risk Risk Passon Child Pass of the following the past three months, have you had more than 4 than the United States, Canada, Australia, New Zealand, or Western and North European countrics)? Western and North E					•	105	
pushed, kicked, physically hurt or threw something at the child? 30 Has your child ever lived away from home for more than a month? 31 Do you help your child brush and floss her/his teeth daily? Yes Unsure No Dental 22 Do you feel your child is difficult to take care of? Never Sometimes Often Often 23 Do you need to hit/spank your child? Never Sometimes Often Often 24 Do you need to hit/spank your child? Never Sometimes Often Often 25 Are you currently living with a spouse or partner? Yes Unsure No Unsure No Often 26 Do you here of the floss parents separated, divorced, or not living to together? 31 Do you here friends or family who help take care of your child? Sometimes Never 27 Did your child ever live with anyone who went to prison, jail or other correctional facility? 32 Do you have friends or family who help take care of your child? Sometimes Never 28 Does your family look out for each other, feel close to each other and support each other? 40 Over the past 2 weeks, how often have you been bothered by any of the following problems? 41. Little interest or pleasure in doing things A.2. Feeling down, depressed, or hopeless B.1. Feeling nervous, anxious or on edge 0 1 2 3 Total Part A: B.1. Feeling nervous, anxious or on edge 0 1 2 3 Total Part A: B.1. Did your child ever live with anyone who was depressed, mentally ill or suicidal? 42 Does your child spend time with anyone who smokes? No Unsure Yes Substance 43 During the past three months, have you had more than 4 No Unsure Yes Substance 44 Did your child ever live with anyone who had a problem with drugs or alcohol? 45 Do you know or are you concerned that your child was ever touched, or asked to touch, an adult or someone at least 5 years older sexually? Has a family member had a positive tuberculin skin test result? 46 Has a family member had a positive tuberculin skin test result? 47 Has a family member had a positive tuberculin skin test result? 48 Was your child born in a high-risk country (countries other than the United States, Canada, Au		hitting, kicking or physically threatening each other?	No	1	Unsure	Yes	
month? 10 Do you help your child brush and floss her/his teeth daily? 11 Do you help your child brush and floss her/his teeth daily? 12 Do you feel your child is difficult to take care of? 13 Do you feel your child is difficult to take care of? 14 Do you need to hit/spank your child? 15 Are you currently living with a spouse or partner? 16 Are your child's parents separated, divorced, or not living together? 17 Do you need to hit/spank your child? 18 Are your child's parents separated, divorced, or not living together? 18 Are your child's parents separated, divorced, or not living together? 19 Do you rehild ever live with anyone who went to prison, jail or other correctional facility? 10 Do you have friends or family who help take care of your child? 10 Does your family look out for each other, feel close to each other and support each other? 10 Over the past 2 weeks, how often have you been bothered by any of the following problems? 11 Little interest or pleasure in doing things 12 A2. Feeling down, depressed, or hopeless 13 B2. Not being able to stop or control worrying 14 Did your child ever live with anyone who was depressed, mentally ill or suicidal? 15 Did your child ever live with anyone who was depressed, no unsure yes mentally ill or suicidal? 16 Does your child spend time with anyone who smokes? 17 Did your child ever live with anyone who had a problem with fungs or alcohol? 18 Did you know or are you concerned that your child was ever touched, or asked to touch, an adult or someone at least 5 years older sexually? 18 Did you whom or are you concerned that your child was ever touched, or asked to touch, an adult or someone at least 5 years older sexually? 19 Do you know or are you concerned that your child was ever touched, or asked to touch, an adult or someone at least 5 years older sexually? 19 Do you know or are you concerned that your child was ever fouched, or asked to touch, an adult or someone at least 5 years older sexually? 10 Do you know or are you concerned that t	29	pushed, kicked, physically hurt or threw something at the	No	1	Unsure	Yes	
31 Do you help your child brush and floss her/his teeth daily? Yes Unsure No Dental	30		No	1	Unsure	Yes	
32 Do you feel your child is difficult to take care of? Never Sometimes Often Often	31		Yes	1	Unsure	No	Dental
33 Do you swear at or insult your child? Never Sometimes Often	32		Never	So	metimes	Often	
34 Do you need to hit/spank your child? Never Sometimes Often	33		Never	So	metimes	Often	_
35 Are you currently living with a spouse or partner? Yes Unsure No		, , , , , , , , , , , , , , , , , , ,					
Are your child's parents separated, divorced, or not living together?		· · ·					
Did your child ever live with anyone who went to prison, jail or other correctional facility? Often Sometimes Never child?		Are your child's parents separated, divorced, or not living					
jail or other correctional facility?	27	E					
Child? Often Sometimes Never	3/	_ · · · · · · · · · · · · · · · · · · ·	No	1	Unsure	Yes	
each other and support each other? 40 Over the past 2 weeks, how often have you been bothered by any of the following problems? A1. Little interest or pleasure in doing things A2. Feeling down, depressed, or hopeless B1. Feeling nervous, anxious or on edge B2. Not being able to stop or control worrying 41 Did your child ever live with anyone who was depressed, mentally ill or suicidal? 42 Does your child spend time with anyone who smokes? 43 During the past three months, have you had more than 4 drinks containing alcohol in one day? 44 Did your child ever live with anyone who had a problem with drugs or alcohol? 45 Do you know or are you concerned that your child was ever touched, or asked to touch, an adult or someone at least 5 years older sexually? 46 Has a family member or contact had tuberculosis disease? 48 Was your child born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)? 49 Has your child traveled (had contact with resident Often Not at all Several days More than had Several moders had solved and positive tuberculine skin test result? No Unsure Ves Substance Exposure Yes Sexual Issues Vo Unsure Yes Tuberculosis Risk	38		Often	Sometimes		Never	
Over the past 2 weeks, how often have you been bothered by any of the following problems?	39	· · · · · · · · · · · · · · · · · · ·	Often	Sometimes		Never	
by any of the following problems? A1. Little interest or pleasure in doing things A2. Feeling down, depressed, or hopeless B1. Feeling nervous, anxious or on edge B2. Not being able to stop or control worrying Did your child ever live with anyone who was depressed, mentally ill or suicidal? A2. Does your child spend time with anyone who smokes? Does your child spend time with anyone who smokes? A3. Total Part A: Total Part B: Was pour child ever live with anyone who smokes? A4. Did your child ever live with anyone who smokes? A5. No B2. Not being able to stop or control worrying Did your child ever live with anyone who was depressed, mentally ill or suicidal? A5. Does your child spend time with anyone who smokes? A6. Does your child ever live with anyone who had a problem with drugs or alcohol? A6. Do you know or are you concerned that your child was ever touched, or asked to touch, an adult or someone at least 5 years older sexually? A6. Has a family member or contact had tuberculosis disease? A7. Has a family member had a positive tuberculin skin test result? A8. Was your child born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)? A8. Was your child traveled (had contact with resident A9. Unsure Yes Tuberculosis Risk Was your child traveled (had contact with resident No Unsure Yes Tuberculosis Risk	40		Not at	Several	More than	Nearly every	3.6 1
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Does your child spend time with anyone who smokes? No Unsure Yes Substance	41	Did your child ever live with anyone who was depressed,	No	1	Unsure	Yes	
During the past three months, have you had more than 4 drinks containing alcohol in one day? 44 Did your child ever live with anyone who had a problem with drugs or alcohol? 45 Do you know or are you concerned that your child was ever touched, or asked to touch, an adult or someone at least 5 years older sexually? 46 Has a family member or contact had tuberculosis disease? No Unsure Yes Tuberculosis Has a family member had a positive tuberculin skin test result? 48 Was your child born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)? 49 Has your child traveled (had contact with resident No Unsure Yes Ves		mentally ill or suicidal?					
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Did your child ever live with anyone who had a problem with drugs or alcohol?	43		No	1	Unsure	Yes	Exposure
Do you know or are you concerned that your child was ever touched, or asked to touch, an adult or someone at least 5 years older sexually? Unsure Yes Issues	44	Did your child ever live with anyone who had a problem	No	1	Unsure	Yes	
ever touched, or asked to touch, an adult or someone at least 5 years older sexually? 46 Has a family member or contact had tuberculosis disease? No Unsure Yes Tuberculosis 47 Has a family member had a positive tuberculin skin test result? 48 Was your child born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)? 49 Has your child traveled (had contact with resident No Unsure Yes	15						Coveral
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47 Has a family member had a positive tuberculin skin test result? No Unsure Yes Risk 48 Was your child born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)? No Unsure Yes 49 Has your child traveled (had contact with resident No Unsure Yes	16		No	1	(Imaxima	Vac	Tukamanlasia
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than the United States, Canada, Australia, New Zealand, or Western and North European countries)? 49 Has your child traveled (had contact with resident No Unsure Yes	18		No	1	Incure	Vac	
Western and North European countries)? 49 Has your child traveled (had contact with resident No Unsure Yes	+0		INO		Onsuit	1 68	
49 Has your child traveled (had contact with resident No Unsure Yes							
	10		No	1	Incure	Vac	
	+7		TNU		Olisuit	168	

50	Do you have a high school degree?	Yes	S	Unsure	No	Other
						Questions
51	Are you doing something to keep yourself (or your			, IUD or implant		
	partner) from getting pregnant?	□ '	Yes,	, permanent (e.g. tubes t	tied or	
				ectomy)		
				, other birth control		
				pregnant		
				trying to get pregnant		
			No			
52	Do you have concerns about how your child speaks?	No)	Unsure	Yes	
53	Do you have any other questions or concerns about your	No)	Unsure	Yes	
	child's health, development, or behavior?					

Clinic Use Only			Provided	Ordered	Comments
Screened	Counseled	Referred	Handout	Follow-up	
□ Nutrition					
□ Physical Activity					
□ Sleep					
□ Safety					
□ Dental Health					
□ Parenting Stress					
□ Mental Health					
□ Substances					
□ Sexual					□ Patient Declined WCA
□ Tuberculosis					
□ Other					
PCP's Signature		F	Print Name		Date

Whole Child Assessment for Ages 5-8 Years

THE CITE TENDERS		•			
Child's Name (first & last)	Date of Birth	□ Female		Today's Date	School/Grade in School
		□ M	ale		
Person Completing Form	□ Biological Pare	nt	Schoo	1 Attendance	School Grades
□ Relative	□ Step Parent		Regula	ar? □ Yes	□ Average or Better than average
□ Friend	□ Adopted Parent			□ No	□ Below average or Poor
□ Other (specify)	□ Foster Parent				

	hild be healthy. You may skip any question if you do not know an answer or do not want to nswer. You may add comments to explain your answers. We will keep this information confidential, nless there's concern that your child is being hurt.									
1	Does your child eat breakfast every day?	Yes	Unsure	No	Nutrition					
2	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	Unsure	No						
3	Does your child eat fruits and vegetables at least 2 times per day ?	Yes	Unsure	No	-					
4	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Unsure	Yes						
5	Does your child drink <u>more than one</u> small cup (4 - 6 oz.) of juice per day ?	No	Unsure	Yes	-					
6	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week ?	No	Unsure	Yes						
7	In the past year, did you worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often						
8	Does your child exercise or play sports <u>most days</u> of the week?	Yes	Unsure	No	Physical Activity					
9	Does your child watch TV or play video games less than 2 hours per day?	Yes	Unsure	No	-					
10	Are you concerned about your child's weight?	No	A little	Yes						
11	Does your child have trouble falling asleep or staying asleep?	No	Sometimes	Yes	Sleep					
12	Does your home have a working smoke detector?	Yes	Unsure	No	Safety					
13	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	Unsure	No	-					
14	Does your home have the phone number of the Poison Control Center (800-222-1222) posted?	Yes	Unsure	No	-					
15	Do you always place your child in a booster seat in the back seat (or use a seat belt if your child is over 4'9")?	Yes	Unsure	No						
16	Does your child spend time near a swimming pool, river, or lake?	No	Unsure	Yes						
17	Does your child spend time in a home where a gun is kept?	No	Unsure	Yes						
18	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Unsure	Yes						
19	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	Doesn't ride	No						
20	In the past year, have you felt safe in your relationship?	Yes	No partner	No						
21	In the past year, have you and your partner fought a lot?	No	No partner	Yes						
22	Has your child ever witnessed adults in the home pushing, hitting, kicking or physically threatening each other?	No	Unsure	Yes						

23	Has your child ever lived with a parent or other adult who pushed, kicked, physically hurt or threw something at the	No	Ţ	Unsure	Yes	
24	child? Does your child have trouble with anger or get into fights with other children?	No	Ţ	Unsure	Yes	
25	Has your child ever lived away from home for more than a month?	No	Ţ	Unsure	Yes	
26	Has your child ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Ţ	Unsure	Yes	
27	Does your child brush and floss her/his teeth daily?	Yes	Ţ	Unsure	No	Dental
28	Do you feel your child is difficult to take care of?	Never	So	metimes	Often	Parenting
29	Do you swear at or insult your child?	Never	So	metimes	Often	Stress
30	Do you need to hit/spank your child?	Never	So	metimes	Often	
31	Are you currently living with a spouse or partner?	Yes	Ţ	Unsure	No	
32	Are your child's parents separated, divorced, or not living together?	No	τ	Unsure	Yes	
33	Did your child ever live with anyone who went to prison, jail or other correctional facility?	No	Ţ	Unsure	Yes	
34	Do you have friends or family who help take care of your child?	Often	So	metimes	Never	
35	Does your family look out for each other, feel close to each other and support each other?	Often	So	metimes	Never	
36	Does your child often seem sad or depressed?	No	Ţ	Unsure	Yes	Montol
37	Over the past 2 weeks, how often have you been bothered	Not at	Several	More than	Nearly	Mental Health
	by any of the following problems?	all	days	half the days	every day	пеанн
	A1. Little interest or pleasure in doing things	0	1	2	2	
	A2. Feeling down, depressed, or hopeless	0	1 1	2 2	3 3	Total Part A:
	B1. Feeling nervous, anxious or on edge	0	1	2	3	
	B2. Not being able to stop or control worrying	0	1	2	3	Total Part B
38	Did your child ever live with anyone who was depressed, mentally ill or suicidal?	No	Ţ	Unsure	Yes	
39	Does your child spend time with anyone who smokes?	No	Ţ	Unsure	Yes	Substance
40	During the past three months, have you had more than 4 drinks containing alcohol in one day?	No	ı	Unsure	Yes	Exposure
41	Did your child ever live with anyone who had a problem with drugs or alcohol?	No	Ţ	Unsure	Yes	
42	Do you know or are you concerned that your child was ever touched, or asked to touch, an adult or someone at least 5 years older sexually?	No	Ţ	Unsure	Yes	Sexual Issues
43	Has a family member or contact had tuberculosis disease?	No	τ	Unsure	Yes	Tuberculosis
44	Has a family member had a positive tuberculin skin test result?	No		Unsure	Yes	Risk
45	Was your child born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)?	No	J	Unsure	Yes	
46	Has your child traveled (had contact with resident populations) to a high-risk country for more than 1 week?	No	J	Unsure	Yes	

47	Do you have a high school degree?	Yes	Unsure	No	Other
48	Do you have any other questions or concerns about your	No	Unsure	Yes	Questions
	child's health or behavior?				

Clinic Use Only Screened	Counseled	Referred	Provided Handout	Ordered Follow-up	Comments
□ Nutrition					
□ Physical Activity					
□ Sleep					
□ Safety					
□ Dental Health					
□ Parenting Stress					
□ Mental Health					
□ Substances					
□ Sexual					□ Patient Declined WCA
□ Tuberculosis					
□ Other					
PCP's Signature		I	Print Name		Date

Whole Child Assessment for Ages 9-11 Years

Child's Name (first & last)	Date of Birth	□ Female		Today's Date	School/Grade in School
		□ M	ale		
Person Completing Form	□ Biological Pare	ent	School	ol Attendance	School Grades
□ Relative	□ Step Parent		Regul	ar? □ Yes	☐ Average or Better than average
□ Friend	□ Adopted Paren	ent		□ No	□ Below average or Poor
□ Other (specify)	☐ Foster Parent				

chil ans	ase answer all the questions on this form as best you can. It weld be healthy. You may skip any question if you do not know wer. You may add comments to explain your answers. We will ess there's concern that your child is being hurt.	an answei	r or do not want to		Clinic Use Only:
1	Does your child eat breakfast every day ?	Yes	Unsure	No	Nutrition
2	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	Unsure	No	
3	Does your child eat fruits and vegetables at least 2 times per day ?	Yes	Unsure	No	1
4	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Unsure	Yes	1
5	Does your child drink more than one cup (8 oz.) of juice per day ?	No	Unsure	Yes	1
6	Does your child drink soda, juice, sports drinks, energy drinks, or other sweetened drinks more than once per week ?	No	Unsure	Yes	
7	In the past year, did you worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often	
8	Does your child exercise or play sports <u>most days</u> of the week?	Yes	Unsure	No	Physical Activity
9	Does your child watch TV or play video games less than 2 hours per day?	Yes	Unsure	No	1
10	Are you concerned about your child's weight?	No	A little	Yes	
11	Does your child have trouble falling asleep or staying asleep?	No	Sometimes	Yes	Sleep
12	Does your home have a working smoke detector?	Yes	Unsure	No	Safety
13	Does your home have the phone number of the Poison Control Center (800-222-1222) posted?	Yes	Unsure	No	
14	Does your child always use a seat belt in the back seat (or use a booster seat if under 4'9")?	Yes	Unsure	No	_
15	Does your child spend time near a swimming pool, river, or lake?	No	Unsure	Yes	-
16	Does your child spend time in a home where a gun is kept?	No	Unsure	Yes	
17	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Unsure	Yes	1
18	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	Doesn't ride	No	
19	In the past year, have you felt safe in your relationship?	Yes	No partner	No	
20	In the past year, have you and your partner fought a lot?	No	No partner	Yes	
21	Has your child ever witnessed adults in the home pushing, hitting, kicking or physically threatening each other?	No	Unsure	Yes	
22	Has your child ever lived with a parent or other adult who pushed, kicked, physically hurt or threw something at the child?	No	Unsure	Yes	

23	Does your child have trouble with anger or get into fights with other children?	No	τ	Unsure	Yes	
24	Has your child ever lived away from home for more than a month?	No	τ	Insure	Yes	
25	Has your child ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Unsure		Yes	
26	Does your child brush and floss her/his teeth daily?	Yes	ı	Jnsure	No	Dental
27	Do you feel your child is difficult to take care of?	Never		metimes	Often	Parenting
28	Do you swear at or insult your child?	Never		metimes	Often	Stress
29	Do you need to hit/spank your child?	Never		metimes	Often	Buess
30	Are you currently living with a spouse or partner?	Yes		Jnsure	No	
31	Are your child's parents separated, divorced, or not living	103	<u> </u>	Justic	110	
	together?	No	Į	Jnsure	Yes	
32	Did your child ever live with anyone who went to prison, jail or other correctional facility?	No	τ	Jnsure	Yes	
33	Do you have friends or family who help take care of your child?	Often	So	metimes	Never	
34	Does your family look out for each other, feel close to each other and support each other?	Often		metimes	Never	
35	Does your child often seem sad or depressed?	No		Jnsure	Yes	Mental
36	Over the past 2 weeks, how often have you been bothered	Not at	Several	More than	Nearly every	Mental Health
	by any of the following problems?	all	days	half the days	day	пеанн
	A1. Little interest or pleasure in doing things	0				
	A2. Feeling down, depressed, or hopeless	0	1	2 2	3	Total Part A:
	B1. Feeling nervous, anxious or on edge	0	1 1	2	3	Total Latt A.
	B2. Not being able to stop or control worrying	0	1	2	3	Total Part B
37	Did your child ever live with anyone who was depressed,	No	1	Jnsure	Yes	
	mentally ill or suicidal?	1,0		3 113 41 3		
38	Does your child spend time with anyone who smokes?	No	Ţ	Unsure	Yes	Substances
39	Has your child ever smoked cigarettes or chewed tobacco?	No		Jnsure	Yes	Substances
40	Are you concerned your child may be using drugs or	No		Insure	Yes	
40	sniffing substances, such as glue, to get high?	110	`	Justic	103	
41	Are you concerned that your child may be drinking alcohol,	No	ī	Insure	Yes	
71	such as beer, wine, wine coolers, or liquor?	110	`	Justic	103	
42	During the past three months, have you had more than 4					
72	drinks containing alcohol in one day?	No	1	Jnsure	Yes	
43	Did your child ever live with anyone who had a problem	No		Jnsure Jnsure	Yes	
43	with drugs or alcohol?	110	'	Jusuic	103	
44	Has your child started dating or "going out" with boyfriends	No	1	Insure	Yes	Sexual
144	or girlfriends?	110	'	Jusuic	1 68	Issues
45	Do you think your child might be sexually active?	No	No. Linguino		Yes	issues
46	, , , , , , , , , , , , , , , , , , ,				Yes	
40	Do you know or are you concerned that your child was ever	140	No Unsure		1 es	
	touched, or asked to touch, an adult or someone at least 5					
47	years older sexually? Has a family member or contact had tuberculosis disease?	No	1	Insure	Yes	Tuberculosis
+/	rias a rainity member of contact had tuberculosis disease?	110	'	Jusuic	1 68	Risk
48	Has a family member had a positive tuberculin skin test	No	1	Insure	Yes	MISK
+0	result?	110	'	Justic	108	
49	Was your child born in a high-risk country (countries other	No	1	Insure	Yes	
+7	than the United States, Canada, Australia, New Zealand, or	110	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Jusuic	168	
	Western and North European countries)?					

50	Has your child traveled (had contact with resident	No	Unsure	Yes	
	populations) to a high-risk country for more than 1 week?				
51	Do you have a high school degree?	Yes	Unsure	No	Other
52	Do you have any other questions or concerns about your	No	Unsure	Yes	Questions
	child's health or behavior?				

Clinic Use Only			Provided	Ordered	Comments
Screened	Counseled	Referred	Handout	Follow-up	
□ Nutrition					
□ Physical Activity					
□ Sleep					
□ Safety					
□ Dental Health					
□ Parenting Stress					
□ Mental Health					
□ Substances					
□ Sexual Issues					
□ Tuberculosis					□ Patient Declined WCA
□ Other					
PCP's Signature		F	rint Name		Date

Whole Child Assessment for Ages 12-17 Years To Be Completed by Patient

Name (first & last)	Dat	te of Birth	□ Female	Today's Date	School/Grade	School Attendance
			□ Male			Regular? Yes
						□ No
IF YOU NEED ASSIS	STANCE COM	PLETING THI	S FORM, P	LEASE	School Grades	
INDICATE WHO ASSISTED:					□ Average or Better th	nan average
☐ Biological Parent	□ Step Parent	t □ Adopted	l Parent	Foster Parent	☐ Below average or Po	oor
□ Relative	□ Friend	□ Other (sp	ecify)			
			•			

be l may	ase answer all the questions on this form as best you can. It with healthy. You may skip any question if you do not know an ans y add comments to explain your answers. We will keep this info cern that you are being hurt.	wer or do	not want to answ	er. You	Clinic Use Only:
1	Do you eat breakfast every day ?	Yes	Unsure	No	Nutrition
2	Do you drink or eat 3 servings of calcium-rich foods daily , such as milk, cheese, yogurt, soy milk, or tofu?	Yes	Unsure	No	
3	Do you eat fruits and vegetables <u>at least 2</u> times per day ?	Yes	Unsure	No	
4	Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week ?	No	Unsure	Yes	
5	Do you drink <u>more than 12 oz</u> . (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Unsure	Yes	
6	In the past year, did you or your family worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often	
7	Do you exercise or play sports <u>most days</u> of the week?	Yes	Unsure	No	Physical
8	Do you watch TV or play video games <u>less than 2</u> hours per day ?	Yes	Unsure	No	Activity
9	Are you concerned about your weight?	No	Unsure	Yes	
10	Do you have trouble falling asleep or staying asleep?	No	Unsure	Yes	Sleep
11	Does your home have a working smoke detector?	Yes	Unsure	No	Safety
12	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	Unsure	No	
13	Do you always wear a seat belt when riding in a car?	Yes	Unsure	No	
14	Do you spend time in a home where a gun is kept?	No	Unsure	Yes	
15	Do you spend time with anyone who carries a gun, knife, or other weapon?	No	Unsure	Yes	
16	Do you always wear a helmet when riding a bike, skateboard, or scooter?	Yes	Don't ride	No	
17	In the past year , have you felt afraid of someone you were dating?	No	Not dating	Yes	
18	Have you ever witnessed adults in the home pushing, hitting, kicking, or physically threatening each other?	No	Unsure	Yes	
19	Did you ever live with anyone who often shouted or yelled at you?	No	Unsure	Yes	
20	Did you ever live with anyone who acted in a way that made you feel afraid?	No	Unsure	Yes	
21	Did a parent or other adult ever hit you so hard that you had marks or were injured?	No	Unsure	Yes	
22	Have you ever lived away from home for more than a month?	No	Unsure	Yes	

23	Have you been hit, slapped, kicked, or physically hurt by	No	U	nsure	Yes	
	anyone (or have you hurt anyone) in the past year ?					
24	Have you ever been bullied or felt unsafe at school or in	No	U	nsure	Yes	
	your neighborhood (or been cyber-bullied)?					
25	Do you brush and floss your teeth daily?	Yes	Unsure		No	Dental
26	Are your parents separated, divorced, or not living	No	U	nsure	Yes	Stress
	together?					
27	Has your parent or anyone you ever lived with went to	No	T	nsure	Yes	
	prison, jail or other correctional facility?	NO	U	lisuie	1 68	
28	Do you feel that no one in your family loves you or	Never	Sor	netimes	Often	
	thinks that you are important or special?	Nevel	301	neumes	Often	
29	Does your family look out for each other, feel close to each	Often	Sor	netimes	Never	
	other and support each other?		301	neumes	Nevel	
30	Did you ever live with anyone who was depressed, mentally	No	U	nsure	Yes	Mental
	ill or suicidal?					Health
31	Over the past 2 weeks, how often have you been bothered by	Not at		More than	Nearly	
	any of the following problems?	all	days	half the days	every day	
	A1. Little interest or pleasure in doing things		1	2	2	
	A2. Feeling down, depressed, or hopeless	$\begin{bmatrix} 0 \\ 0 \end{bmatrix}$	1 1	2 2	3 3	Total Part A:
	B1. Feeling nervous, anxious or on edge	0	1	2	3	
	B2. Not being able to stop or control worrying			3	Total Part B	
32	During the past 3 months, have you thought of killing	No	U	nsure	Yes	
	yourself?					
33	Do you spend time with anyone who smokes?	No	U	nsure	Yes	Substance
34	Do you smoke cigarettes or chew tobacco?	No	U	nsure	Yes	Exposure
35	Do you use or sniff any substance to get high, such as	No	U	nsure	Yes	
	marijuana, cocaine, crack, Methamphetamine (meth),					
	ecstasy, etc.?					
36	Do you use medicines not prescribed for you?	No	U	nsure	Yes	
37	Do you drink alcohol once a week or more?	No	U	nsure	Yes	
38	If you drink alcohol, do you drink enough to get drunk or	No	Dor	't drink	Yes	
	pass out?					
39	Do you drive a car after drinking, or ride in a car driven by	No	U	nsure	Yes	
	someone who has been drinking or using drugs?					
40	Do you spend time with anyone who uses drugs or drinks	No	T 1		Vac	
	too much alcohol?	No	U	nsure	Yes	
41	Did you ever live with anyone who had a problem with				**	
	drugs or alcohol?	No	U	nsure	Yes	
	Your answers about sex and family planning cannot be shared with a	nvone. ii	ncluding v	our parents, v	vithout vour	permission.
42	Have you ever been touched, or asked to touch, an adult or	No		nsure	Yes	Sexual Issues
	someone at least 5 years older sexually?					
43	Have you ever been forced or pressured to have sex?	No	U	nsure	Yes	
44	Have you ever had sex (oral, vaginal, or anal)?	No	U	nsure	Yes	
		If no, s	skip to que	estion 46	ı	

15	1 1 2 1 10 1 1				
45	Answer these questions only if you ever had sex:				
	a. Do you think you or your partner could have a sexually				
	transmitted infection (STI), such as Chlamydia,	No	Unsure	Yes	
	Gonorrhea, genital warts, etc.?				
	b. Have you or your partner(s) had sex with other people in	No	Unsure	Yes	
	the past year?			37	
	c. Have you or your partner(s) had sex without using birth	No	Unsure	Yes	
	control in the past year?	No	T.T.,	Yes	
	d. The last time you had sex, did you use birth control?	NO	Unsure	103	
	e. Have you or your partner(s) had sex without a condom	No	Unsure	Yes	
	in the past year?	110	Chistre		
	f. Did you or your partner use a condom the last time you had sex?	No	Unsure	Yes	
46		No	Unsure	Yes	
40	Do you have any questions about your sexual orientation	INO	Ulisure	168	
	(who you are attracted to) or gender identity (how you feel as				
47	a boy, girl, or other gender)?	No	Unsure	Yes	Tubanaulasia
47	Has a family member or contact had tuberculosis disease?	NO	Unsure	ies	Tuberculosis
40	The after the manch of a discount for the manch of the discount for the di	NI.	T.I.,	V	Risk
48	Has a family member had a positive tuberculin skin test	No	Unsure	Yes	
40	result?	No	T.I.,	Yes	
49	Were you born in a high-risk country (countries other than	No	Unsure	Yes	
	the United States, Canada, Australia, New Zealand, or				
50	Western and North European countries)?		I I	V	
50	Have you traveled (had contact with resident populations) to		Unsure	Yes	
<i>5</i> 1	a high-risk country for more than 1 week?		T.T	NT.	0.1
51	Does your primary caregiver (parent or guardian) have a		Unsure	No	Other
-50	high school degree?		**	*7	Questions
52	Do you have any other questions or concerns about your	No	Unsure	Yes	
	health? If yes, please describe				

Clinic Use Only			Provided	Ordered	Comments
Screened	Counseled	Referred	Handout	Follow-up	
□ Nutrition					
□ Physical Activity					
□ Sleep					
□ Safety					
□ Dental Health					
□ Parenting Stress					
□ Mental Health					
□ Substances					
□ Sexual Issues					
□ Tuberculosis					□ Patient Declined WCA
□ Other					
PCP's Signature		F	Print Name		Date