

## Whole Child Assessment for Ages 0-6 Months

Child's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date	In Child/Daycare? <input type="checkbox"/> Yes <input type="checkbox"/> No
Person Completing Form <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other (specify)	<input type="checkbox"/> Biological Parent <input type="checkbox"/> Step Parent <input type="checkbox"/> Adopted Parent <input type="checkbox"/> Foster Parent			

<p><i>Please answer all the questions on this form as best you can. It will help us know how we can help your child be healthy. <b>You may skip any question if you do not know an answer or do not want to answer.</b> You may add comments to explain your answers. We will keep this information confidential, unless there's concern that your child is being hurt.</i></p>					<b>Clinic Use Only:</b>
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	<b>In the past month</b> , did you run out of formula for your baby?	No	Breastfeed	Yes	
5	<b>In the past year</b> , 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 Activity
7	Does your baby watch any TV?	No	Unsure	Yes	
8	Do you <b>always</b> 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 <b>always</b> stay with your baby when s/he is in the bathtub?	Yes	Unsure	No	
15	Do you <b>always</b> 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	<b>In the past year</b> , have you felt safe in your relationship?	Yes	No partner	No	
19	<b>In the past year</b> , have you and your partner fought a lot?	No	No partner	Yes	
20	Has your baby <b>ever</b> witnessed adults in the home pushing, hitting, kicking <b>or</b> physically threatening each other?	No	Unsure	Yes	
21	Has your baby <b>ever</b> 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 Stress
25	Are you currently living with a spouse or partner?	Yes	Unsure	No	
26	Are your baby's parents separated, divorced, or not living together?	No	Unsure	Yes	

27	Did your baby <b>ever</b> live with anyone who went to prison, jail or other correctional facility?	No	Unsure	Yes		
28	Do you have friends or family who help take care of your baby?	Often	Sometimes	Never		
29	Does your family look out for each other, feel close to each other and support each other?	Often	Sometimes	Never		
30	Over the past <b>2 weeks</b> , 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	Not at all	Several days	More than half the days	Nearly every day	Mental Health Total Part A: Total Part B:
31	Did your baby <b>ever</b> live with anyone who was depressed, mentally ill or suicidal?	No	Unsure	Yes		
32	Does your baby spend time with anyone who smokes?	No	Unsure	Yes	Substance Exposure	
33	During the past three months, have you had <b>more than 4 drinks</b> containing alcohol in one day?	No	Unsure	Yes		
34	Did your baby <b>ever</b> live with anyone who had a problem with drugs or alcohol?	No	Unsure	Yes		
35	Has a family member or contact had tuberculosis disease?	No	Unsure	Yes	Tuberculosis Risk	
36	Has a family member had a positive tuberculin skin test result?	No	Unsure	Yes		
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	Unsure	Yes		
38	Has your baby traveled (had contact with resident populations) to a high-risk country for more than 1 week?	No	Unsure	Yes		
39	Do you have a high school degree?	Yes	Unsure	No	Other Questions	
40	Are you doing something to keep yourself (or your partner) from getting pregnant?	<input type="checkbox"/> Yes, IUD or implant <input type="checkbox"/> Yes, permanent (e.g. tubes tied or vasectomy) <input type="checkbox"/> Yes, other birth control <input type="checkbox"/> No, pregnant <input type="checkbox"/> No, trying to get pregnant <input type="checkbox"/> No				
41	Do you have any other questions or concerns about your baby's health, development, or behavior?	No	Unsure	Yes		

*If yes, please describe:*

<i>Clinic Use Only</i> Screened	Counseled	Referred	Provided Handout	Ordered Follow-up	Comments
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined WCA
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Parenting Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature	Print Name			Date	

## Whole Child Assessment for Ages 7-12 Months

Child's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date	In Child/Daycare? <input type="checkbox"/> Yes <input type="checkbox"/> No
Person Completing Form <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other (specify)	<input type="checkbox"/> Biological Parent <input type="checkbox"/> Step Parent <input type="checkbox"/> Adopted Parent <input type="checkbox"/> Foster Parent			

<p><i>Please answer all the questions on this form as best you can. It will help us know how we can help your child be healthy. <b>You may skip any question if you do not know an answer or do not want to answer.</b> You may add comments to explain your answers. We will keep this information confidential, unless there's concern that your child is being hurt.</i></p>					<b>Clinic Use Only:</b>
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	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	<b>In the past month</b> , did you run out of formula for your baby?	No	Breastfeed	Yes	
6	<b>In the past year</b> , 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 Activity
8	Does your baby watch any TV?	No	Unsure	Yes	
9	Do you <b>always</b> 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 <b>always</b> stay with your child when s/he is in the bathtub?	Yes	Unsure	No	
16	Do you <b>always</b> 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	<b>In the past year</b> , have you felt safe in your relationship?	Yes	No partner	No	
21	<b>In the past year</b> , have you and your partner fought a lot?	No	No partner	Yes	
22	Has your baby <b>ever</b> witnessed adults in the home pushing, hitting, kicking <b>or</b> physically threatening each other?	No	Unsure	Yes	
23	Has your baby <b>ever</b> lived with a parent or other adult who shook or threw the baby?	No	Unsure	Yes	
24	Has your baby <b>ever</b> 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	Sometimes	Often	Parenting Stress	
27	Are you currently living with a spouse or partner?	Yes	Unsure	No		
28	Are your baby's parents separated, divorced, or not living together?	No	Unsure	Yes		
29	Did your baby <b>ever</b> live with anyone who went to prison, jail or other correctional facility?	No	Unsure	Yes		
30	Do you have friends or family who help take care of your baby?	Often	Sometimes	Never		
31	Does your family look out for each other, feel close to each other and support each other?	Often	Sometimes	Never		
32	Over the past <b>2 weeks</b> , 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	Not at all	Several days	More than half the days	Nearly every day	Mental Health
		0	1	2	3	
		0	1	2	3	Total Part A:
		0	1	2	3	Total Part B:
		0	1	2	3	
33	Did your baby <b>ever</b> live with anyone who was depressed, mentally ill or suicidal?	No	Unsure	Yes	Substance Exposure	
34	Does your baby spend time with anyone who smokes?	No	Unsure	Yes		
35	During the past three months, have you had <b>more than 4 drinks</b> containing alcohol in one day?	No	Unsure	Yes		
36	Did your baby <b>ever</b> live with anyone who had a problem with drugs or alcohol?	No	Unsure	Yes		
37	Has a family member or contact had tuberculosis disease?	No	Unsure	Yes	Tuberculosis Risk	
38	Has a family member had a positive tuberculin skin test result?	No	Unsure	Yes		
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	Unsure	Yes		
40	Has your baby traveled (had contact with resident populations) to a high-risk country for more than 1 week?	No	Unsure	Yes		
41	Do you have a high school degree?	Yes	Unsure	No	Other Questions	
42	Are you doing something to keep yourself (or your partner) from getting pregnant?	<input type="checkbox"/> Yes, IUD or implant <input type="checkbox"/> Yes, permanent (e.g. tubes tied or vasectomy) <input type="checkbox"/> Yes, other birth control <input type="checkbox"/> No, pregnant <input type="checkbox"/> No, trying to get pregnant <input type="checkbox"/> No				
43	Do you have any other questions or concerns about your baby's health, development, or behavior?	No	Unsure	Yes		

*If yes, please describe:*

<i>Clinic Use Only</i> Screened	Counseled	Referred	Provided Handout	Ordered Follow-up	Comments
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined WCA
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Parenting Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature			Print Name		Date



24	Does your child spend time near a swimming pool, river, or lake?	No	Unsure	Yes		
25	Does your child spend time in a home where a gun is kept?	No	Unsure	Yes		
26	Does your child <b>always</b> wear a helmet when riding a bike, skateboard, or scooter?	Yes	Doesn't ride	No		
27	<b>In the past year</b> , have you felt safe in your relationship?	Yes	No partner	No		
28	<b>In the past year</b> , have you and your partner fought a lot?	No	No partner	Yes		
29	Has your child <b>ever</b> witnessed adults in the home pushing, hitting, kicking <b>or</b> physically threatening each other?	No	Unsure	Yes		
30	Has your child <b>ever</b> lived with a parent or other adult who pushed, kicked, physically hurt or threw something at the child?	No	Unsure	Yes		
31	Has your child <b>ever</b> lived away from home for more than a month?	No	Unsure	Yes		
32	Do you help your child brush and floss her/his teeth daily?	Yes	Unsure	No	Dental	
33	Do you feel your child is difficult to take care of?	Never	Sometimes	Often	Parenting Stress	
34	Do you swear at or insult your child?	Never	Sometimes	Often		
35	Do you need to hit/spank your child?	Never	Sometimes	Often		
36	Are you currently living with a spouse or partner?	Yes	Unsure	No		
37	Are your child's parents separated, divorced, or not living together?	No	Unsure	Yes		
38	Did your child <b>ever</b> live with anyone who went to prison, jail or other correctional facility?	No	Unsure	Yes		
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 <b>2 weeks</b> , 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	Not at all	Several days	More than half the days	Nearly every day	Mental Health
		0	1	2	3	Total Part A:
		0	1	2	3	Total Part B:
		0	1	2	3	
		0	1	2	3	
42	Did your child <b>ever</b> live with anyone who was depressed, mentally ill or suicidal?	No	Unsure	Yes		
43	Does your child spend time with anyone who smokes?	No	Unsure	Yes	Substance Exposure	
44	During the past three months, have you had <b>more than 4 drinks</b> containing alcohol in one day?	No	Unsure	Yes		
45	Did your child <b>ever</b> live with anyone who had a problem with drugs or alcohol?	No	Unsure	Yes		
46	Do you know or are you concerned that your child was <b>ever</b> touched, or asked to touch, an adult or someone at least 5 years older sexually?	No	Unsure	Yes	Sexual Issues	
47	Has a family member or contact had tuberculosis disease?	No	Unsure	Yes	Tuberculosis Risk	
48	Has a family member had a positive tuberculin skin test result?	No	Unsure	Yes		
49	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		
50	Has your child traveled (had contact with resident populations) to a high-risk country for more than 1 week?	No	Unsure	Yes		

51	Do you have a high school degree?	Yes	Unsure	No	Other Questions
52	Are you doing something to keep yourself (or your partner) from getting pregnant?	<input type="checkbox"/> Yes, IUD or implant <input type="checkbox"/> Yes, permanent (e.g. tubes tied or vasectomy) <input type="checkbox"/> Yes, other birth control <input type="checkbox"/> No, pregnant <input type="checkbox"/> No, trying to get pregnant <input type="checkbox"/> 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 child's health, development, or behavior?	No	Unsure	Yes	

*If yes, please describe:*

<i>Clinic Use Only</i>	Counseled	Referred	Provided Handout	Ordered Follow-up	Comments
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined WCA
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Parenting Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature	Print Name			Date	



## Whole Child Assessment for Ages 3 – 4 Years

Child's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date	In Child/Daycare? <input type="checkbox"/> Yes <input type="checkbox"/> No
Person Completing Form <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other (specify)	<input type="checkbox"/> Biological Parent <input type="checkbox"/> Step Parent <input type="checkbox"/> Adopted Parent <input type="checkbox"/> Foster Parent			

<p><i>Please answer all the questions on this form as best you can. It will help us know how we can help your child be healthy. <b>You may skip any question if you do not know an answer or do not want to answer.</b> You may add comments to explain your answers. We will keep this information confidential, unless there's concern that your child is being hurt.</i></p>					<b>Clinic Use Only:</b> Nutrition
1	Do you take a multivitamin, prenatal vitamin or folic acid?	Yes	Unsure	No	
2	Does your child eat breakfast <b>every day</b> ?	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 <u>at least two times per day</u> ?	Yes	Unsure	No	
5	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza <u>more than once per week</u> ?	No	Unsure	Yes	
6	Does your child drink <u>more than one</u> small cup (4 - 6 oz.) of juice <b>per day</b> ?	No	Unsure	Yes	
7	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks <u>more than once per week</u> ?	No	Unsure	Yes	
8	Is your child enrolled in WIC?	Yes	Unsure	No	
9	<b>In the past year</b> , 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 <u>most days</u> of the week?	Yes	Unsure	No	Physical Activity
11	Does your child watch TV or play video games <u>less than 2 hours per day</u> ?	Yes	Unsure	No	
12	Are you concerned about your child's weight?	No	Unsure	Yes	Sleep
13	Does your child have trouble falling asleep or staying asleep?	No	Unsure	Yes	
14	Does your home have a working smoke detector?	Yes	Unsure	No	Safety
15	Have you turned your water temperature down to low-warm (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 <b>always</b> stay with your child when s/he is in the bathtub?	Yes	Unsure	No	
20	Do you <b>always</b> 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?	No	Unsure	Yes		
24	Does your child spend time in a home where a gun is kept?	No	Unsure	Yes		
25	Does your child <b>always</b> wear a helmet when riding a bike, skateboard, or scooter?	Yes	Doesn't ride	No		
26	<b>In the past year</b> , have you felt safe in your relationship?	Yes	No partner	No		
27	<b>In the past year</b> , have you and your partner fought a lot?	No	No partner	Yes		
28	Has your child <b>ever</b> witnessed adults in the home pushing, hitting, kicking <b>or</b> physically threatening each other?	No	Unsure	Yes		
29	Has your child <b>ever</b> lived with a parent or other adult who pushed, kicked, physically hurt or threw something at the child?	No	Unsure	Yes		
30	Has your child <b>ever</b> lived away from home for more than a month?	No	Unsure	Yes		
31	Do you help your child brush and floss her/his teeth daily?	Yes	Unsure	No	Dental	
32	Do you feel your child is difficult to take care of?	Never	Sometimes	Often	Parenting Stress	
33	Do you swear at or insult your child?	Never	Sometimes	Often		
34	Do you need to hit/spank your child?	Never	Sometimes	Often		
35	Are you currently living with a spouse or partner?	Yes	Unsure	No		
36	Are your child's parents separated, divorced, or not living together?	No	Unsure	Yes		
37	Did your child <b>ever</b> live with anyone who went to prison, jail or other correctional facility?	No	Unsure	Yes		
38	Do you have friends or family who help take care of your child?	Often	Sometimes	Never		
39	Does your family look out for each other, feel close to each other and support each other?	Often	Sometimes	Never		
40	Over the past <b>2 weeks</b> , 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	Not at all 0 0 0 0	Several days 1 1 1 1	More than half the days 2 2 2 2	Nearly every day 3 3 3 3	Mental Health Total Part A: Total Part B:
41	Did your child <b>ever</b> live with anyone who was depressed, mentally ill or suicidal?	No	Unsure	Yes		
42	Does your child spend time with anyone who smokes?	No	Unsure	Yes	Substance Exposure	
43	During the past three months, have you had <b>more than 4 drinks</b> containing alcohol in one day?	No	Unsure	Yes		
44	Did your child <b>ever</b> live with anyone who had a problem with drugs or alcohol?	No	Unsure	Yes		
45	Do you know or are you concerned that your child was <b>ever</b> touched, or asked to touch, an adult or someone at least 5 years older sexually?	No	Unsure	Yes	Sexual Issues	
46	Has a family member or contact had tuberculosis disease?	No	Unsure	Yes	Tuberculosis Risk	
47	Has a family member had a positive tuberculin skin test result?	No	Unsure	Yes		
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 populations) to a high-risk country for more than 1 week?	No	Unsure	Yes		

50	Do you have a high school degree?	Yes	Unsure	No	Other Questions
51	Are you doing something to keep yourself (or your partner) from getting pregnant?	<input type="checkbox"/> Yes, IUD or implant <input type="checkbox"/> Yes, permanent (e.g. tubes tied or vasectomy) <input type="checkbox"/> Yes, other birth control <input type="checkbox"/> No, pregnant <input type="checkbox"/> No, trying to get pregnant <input type="checkbox"/> 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 child's health, development, or behavior?	No	Unsure	Yes	

*If yes, please describe:*

<i>Clinic Use Only</i> Screened	Counseled	Referred	Provided Handout	Ordered Follow-up	Comments
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined WCA
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Parenting Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature		Print Name			Date

## Whole Child Assessment for Ages 5-8 Years

Child's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date	School/Grade in School
Person Completing Form <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other (specify)	<input type="checkbox"/> Biological Parent <input type="checkbox"/> Step Parent <input type="checkbox"/> Adopted Parent <input type="checkbox"/> Foster Parent	School Attendance Regular? <input type="checkbox"/> Yes <input type="checkbox"/> No	School Grades <input type="checkbox"/> Average or Better than average <input type="checkbox"/> Below average or Poor	

<p>Please answer all the questions on this form as best you can. It will help us know how we can help your child be healthy. <b>You may skip any question if you do not know an answer or do not want to answer.</b> You may add comments to explain your answers. We will keep this information confidential, unless there's concern that your child is being hurt.</p>					<b>Clinic Use Only:</b>
1	Does your child eat breakfast <b>every day</b> ?	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 <u>at least 2 times per day</u> ?	Yes	Unsure	No	
4	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza <u>more than once per week</u> ?	No	Unsure	Yes	
5	Does your child drink <u>more than one</u> small cup (4 - 6 oz.) of juice <b>per day</b> ?	No	Unsure	Yes	
6	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks <u>more than once per week</u> ?	No	Unsure	Yes	
7	<b>In the past year</b> , 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 <u>less than 2 hours per day</u> ?	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 <b>always</b> 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 <b>always</b> wear a helmet when riding a bike, skateboard, or scooter?	Yes	Doesn't ride	No	
20	<b>In the past year</b> , have you felt safe in your relationship?	Yes	No partner	No	
21	<b>In the past year</b> , have you and your partner fought a lot?	No	No partner	Yes	
22	Has your child <b>ever</b> witnessed adults in the home pushing, hitting, kicking <b>or</b> physically threatening each other?	No	Unsure	Yes	

23	Has your child <b>ever</b> lived with a parent or other adult who pushed, kicked, physically hurt or threw something at the child?	No	Unsure	Yes		
24	Does your child have trouble with anger or get into fights with other children?	No	Unsure	Yes		
25	Has your child <b>ever</b> lived away from home for more than a month?	No	Unsure	Yes		
26	Has your child <b>ever</b> been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Unsure	Yes		
27	Does your child brush and floss her/his teeth daily?	Yes	Unsure	No	Dental	
28	Do you feel your child is difficult to take care of?	Never	Sometimes	Often	Parenting Stress	
29	Do you swear at or insult your child?	Never	Sometimes	Often		
30	Do you need to hit/spank your child?	Never	Sometimes	Often		
31	Are you currently living with a spouse or partner?	Yes	Unsure	No		
32	Are your child's parents separated, divorced, or not living together?	No	Unsure	Yes		
33	Did your child <b>ever</b> live with anyone who went to prison, jail or other correctional facility?	No	Unsure	Yes		
34	Do you have friends or family who help take care of your child?	Often	Sometimes	Never		
35	Does your family look out for each other, feel close to each other and support each other?	Often	Sometimes	Never		
36	Does your child <b>often</b> seem sad or depressed?	No	Unsure	Yes	Mental Health	
37	Over the past <b>2 weeks</b> , 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	Not at all	Several days	More than half the days		Nearly every day
		0	1	2		3
		0	1	2		3
		0	1	2		3
		0	1	2	3	
38	Did your child <b>ever</b> live with anyone who was depressed, mentally ill or suicidal?	No	Unsure	Yes	Total Part A: Total Part B	
39	Does your child spend time with anyone who smokes?	No	Unsure	Yes	Substance Exposure	
40	During the past three months, have you had <b>more than 4 drinks</b> containing alcohol in one day?	No	Unsure	Yes		
41	Did your child <b>ever</b> live with anyone who had a problem with drugs or alcohol?	No	Unsure	Yes		
42	Do you know or are you concerned that your child was <b>ever</b> touched, or asked to touch, an adult or someone at least 5 years older sexually?	No	Unsure	Yes	Sexual Issues	
43	Has a family member or contact had tuberculosis disease?	No	Unsure	Yes	Tuberculosis Risk	
44	Has a family member had a positive tuberculin skin test result?	No	Unsure	Yes		
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	Unsure	Yes		
46	Has your child traveled (had contact with resident populations) to a high-risk country for more than 1 week?	No	Unsure	Yes		

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

*If yes, please describe:*

<i>Clinic Use Only</i> Screened	Counseled	Referred	Provided Handout	Ordered Follow-up	Comments
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined WCA
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Parenting Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature					
Print Name					

## Whole Child Assessment for Ages 9-11 Years

Child's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date	School/Grade in School
Person Completing Form <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other (specify)	<input type="checkbox"/> Biological Parent <input type="checkbox"/> Step Parent <input type="checkbox"/> Adopted Parent <input type="checkbox"/> Foster Parent	School Attendance Regular? <input type="checkbox"/> Yes <input type="checkbox"/> No	School Grades <input type="checkbox"/> Average or Better than average <input type="checkbox"/> Below average or Poor	

<p><i>Please answer all the questions on this form as best you can. It will help us know how we can help your child be healthy. <b>You may skip any question if you do not know an answer or do not want to answer.</b> You may add comments to explain your answers. We will keep this information confidential, unless there's concern that your child is being hurt.</i></p>					<b>Clinic Use Only:</b>
1	Does your child eat breakfast <b>every day</b> ?	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 <u>at least 2 times per day</u> ?	Yes	Unsure	No	
4	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza <u>more than once per week</u> ?	No	Unsure	Yes	
5	Does your child drink <u>more than one</u> cup (8 oz.) of juice <b>per day</b> ?	No	Unsure	Yes	
6	Does your child drink soda, juice, sports drinks, energy drinks, or other sweetened drinks <u>more than once per week</u> ?	No	Unsure	Yes	
7	<b>In the past year</b> , 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 <u>less than 2 hours per day</u> ?	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	Does your home have the phone number of the Poison Control Center (800-222-1222) posted?	Yes	Unsure	No	
14	Does your child <b>always</b> 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	
18	Does your child <b>always</b> wear a helmet when riding a bike, skateboard, or scooter?	Yes	Doesn't ride	No	
19	<b>In the past year</b> , have you felt safe in your relationship?	Yes	No partner	No	
20	<b>In the past year</b> , have you and your partner fought a lot?	No	No partner	Yes	
21	Has your child <b>ever</b> witnessed adults in the home pushing, hitting, kicking <b>or</b> physically threatening each other?	No	Unsure	Yes	
22	Has your child <b>ever</b> 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	Unsure	Yes		
24	Has your child <b>ever</b> lived away from home for more than a month?	No	Unsure	Yes		
25	Has your child <b>ever</b> 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	Unsure	No	Dental	
27	Do you feel your child is difficult to take care of?	Never	Sometimes	Often	Parenting Stress	
28	Do you swear at or insult your child?	Never	Sometimes	Often		
29	Do you need to hit/spank your child?	Never	Sometimes	Often		
30	Are you currently living with a spouse or partner?	Yes	Unsure	No		
31	Are your child's parents separated, divorced, or not living together?	No	Unsure	Yes		
32	Did your child <b>ever</b> live with anyone who went to prison, jail or other correctional facility?	No	Unsure	Yes		
33	Do you have friends or family who help take care of your child?	Often	Sometimes	Never		
34	Does your family look out for each other, feel close to each other and support each other?	Often	Sometimes	Never		
35	Does your child <b>often</b> seem sad or depressed?	No	Unsure	Yes		
36	Over the past <b>2 weeks</b> , 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	Not at all	Several days	More than half the days	Nearly every day	Mental Health
		0	1	2	3	
		0	1	2	3	Total Part A:
		0	1	2	3	Total Part B
		0	1	2	3	
37	Did your child <b>ever</b> live with anyone who was depressed, mentally ill or suicidal?	No	Unsure	Yes	Substances	
38	Does your child spend time with anyone who smokes?	No	Unsure	Yes		
39	Has your child ever smoked cigarettes or chewed tobacco?	No	Unsure	Yes		
40	Are you concerned your child may be using drugs or sniffing substances, such as glue, to get high?	No	Unsure	Yes		
41	Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?	No	Unsure	Yes		
42	During the past three months, have you had <b>more than 4 drinks</b> containing alcohol in one day?	No	Unsure	Yes		
43	Did your child <b>ever</b> live with anyone who had a problem with drugs or alcohol?	No	Unsure	Yes		
44	Has your child started dating or "going out" with boyfriends or girlfriends?	No	Unsure	Yes	Sexual Issues	
45	Do you think your child might be sexually active?	No	Unsure	Yes		
46	Do you know or are you concerned that your child was <b>ever</b> touched, or asked to touch, an adult or someone at least 5 years older sexually?	No	Unsure	Yes		
47	Has a family member or contact had tuberculosis disease?	No	Unsure	Yes	Tuberculosis Risk	
48	Has a family member had a positive tuberculin skin test result?	No	Unsure	Yes		
49	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		



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

*If yes, please describe:*

<i>Clinic Use Only</i> Screened	Counseled	Referred	Provided Handout	Ordered Follow-up	Comments
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined WCA
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Parenting Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature				Print Name	

## Whole Child Assessment for Ages 12-17 Years

### To Be Completed by Patient

Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date	School/Grade	School Attendance Regular? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>IF YOU NEED ASSISTANCE COMPLETING THIS FORM, PLEASE INDICATE WHO ASSISTED:</i> <input type="checkbox"/> Biological Parent <input type="checkbox"/> Step Parent <input type="checkbox"/> Adopted Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other (specify)				School Grades <input type="checkbox"/> Average or Better than average <input type="checkbox"/> Below average or Poor	

<i>Please answer all the questions on this form as best you can. It will help us know how we can help you 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 you are being hurt.</i>					<b>Clinic Use Only:</b>
1	Do you eat breakfast <b>every day</b> ?	Yes	Unsure	No	Nutrition
2	Do you drink or eat 3 servings of calcium-rich foods <b>daily</b> , 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 <b>per day</b> ?	Yes	Unsure	No	
4	Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza <u>more than once</u> <b>per week</b> ?	No	Unsure	Yes	
5	Do you drink <u>more than 12 oz.</u> (1 soda can) <b>per day</b> of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Unsure	Yes	
6	<b>In the past year</b> , 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 Activity
8	Do you watch TV or play video games <u>less than 2</u> hours <b>per day</b> ?	Yes	Unsure	No	
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 <b>always</b> 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 <b>always</b> wear a helmet when riding a bike, skateboard, or scooter?	Yes	Don't ride	No	
17	In the <b>past year</b> , 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 <b>ever</b> live with anyone who <b>often</b> shouted or yelled at you?	No	Unsure	Yes	
20	Did you <b>ever</b> live with anyone who acted in a way that made you feel afraid?	No	Unsure	Yes	
21	Did a parent or other adult <b>ever</b> hit you so hard that you had marks or were injured?	No	Unsure	Yes	
22	Have you <b>ever</b> lived away from home for more than a month?	No	Unsure	Yes	

23	Have you been hit, slapped, kicked, or physically hurt by anyone (or have you hurt anyone) in the <b>past year</b> ?	No	Unsure	Yes		
24	Have you <b>ever</b> been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Unsure	Yes		
25	Do you brush and floss your teeth daily?	Yes	Unsure	No	Dental	
26	Are your parents separated, divorced, or not living together?	No	Unsure	Yes	Stress	
27	Has your parent or anyone you <b>ever</b> lived with went to prison, jail or other correctional facility?	No	Unsure	Yes		
28	Do you feel that no one in your family loves you or thinks that you are important or special?	Never	Sometimes	Often		
29	Does your family look out for each other, feel close to each other and support each other?	Often	Sometimes	Never		
30	Did you <b>ever</b> live with anyone who was depressed, mentally ill or suicidal?	No	Unsure	Yes	Mental Health	
31	Over the past <b>2 weeks</b> , 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	Not at all	Several days	More than half the days		Nearly every day
		0	1	2		3
		0	1	2		3
		0	1	2		3
		0	1	2	3	
32	During the past <b>3 months</b> , have you thought of killing yourself?	No	Unsure	Yes	Total Part A: Total Part B	
33	Do you spend time with anyone who smokes?	No	Unsure	Yes	Substance Exposure	
34	Do you smoke cigarettes or chew tobacco?	No	Unsure	Yes		
35	Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, Methamphetamine (meth), ecstasy, etc.?	No	Unsure	Yes		
36	Do you use medicines not prescribed for you?	No	Unsure	Yes		
37	Do you drink alcohol once a week or more?	No	Unsure	Yes		
38	If you drink alcohol, do you drink enough to get drunk or pass out?	No	Don't drink	Yes		
39	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Unsure	Yes		
40	Do you spend time with anyone who uses drugs or drinks too much alcohol?	No	Unsure	Yes		
41	Did you <b>ever</b> live with anyone who had a problem with drugs or alcohol?	No	Unsure	Yes		
Your answers about sex and family planning cannot be shared with anyone, including your parents, without your permission.						
42	Have you <b>ever</b> been touched, or asked to touch, an adult or someone at least 5 years older sexually?	No	Unsure	Yes	Sexual Issues	
43	Have you ever been forced or pressured to have sex?	No	Unsure	Yes		
44	Have you ever had sex (oral, vaginal, or anal)?	No	Unsure	Yes		
		If no, skip to question 46				

45	<i>Answer these questions only if you ever had sex:</i> a. Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.? b. Have you or your partner(s) had sex with other people in the past year? c. Have you or your partner(s) had sex without using birth control in the past year? d. The last time you had sex, did you use birth control? e. Have you or your partner(s) had sex without a condom in the past year? f. Did you or your partner use a condom the last time you had sex?	No No No No No No	Unsure Unsure Unsure Unsure Unsure Unsure	Yes Yes Yes Yes Yes Yes		
46	Do you have any questions about your sexual orientation (who you are attracted to) or gender identity (how you feel as a boy, girl, or other gender)?	No	Unsure	Yes		
47	Has a family member or contact had tuberculosis disease?	No	Unsure	Yes		Tuberculosis Risk
48	Has a family member had a positive tuberculin skin test result?	No	Unsure	Yes		
49	Were you 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		
50	Have you traveled (had contact with resident populations) to a high-risk country for more than 1 week?	No	Unsure	Yes		
51	Does your primary caregiver (parent or guardian) have a high school degree?	Yes	Unsure	No	Other Questions	
52	Do you have any other questions or concerns about your health? If yes, please describe	No	Unsure	Yes		

*If yes, please describe:*

<i>Clinic Use Only</i> Screened	Counseled	Referred	Provided Handout	Ordered Follow-up	Comments
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Patient Declined WCA
<input type="checkbox"/> Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Dental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Parenting Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Sexual Issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PCP's Signature		Print Name			Date