Whole Child Assessment for Ages 0-6 Months

G1 11 3 7 (0° + 0 1 +)	5 65 1	Б 1	m 1 1 D :	Y 01 11 175 0	
Child's Name (first & last)	Date of Birth	□ Female	I oday's Date	In Child/Daycare?	
		□ Male	-	□ Yes	□ No
Person Completing Form	☐ Parent ☐ Rel☐ Guardian ☐ Ot		end		

Plea	ase answer all the questions on this form as best you can. It wil	l help us i	know how we can	help vour					
	d stay healthy. You may skip any question if you do not know								
answer. You may add comments to explain your answers. Your answers will be protected as part of									
your child's medical record.									
1	Do you breastfeed your baby?	No	Only: Nutrition						
2	Do you take a multivitamin, prenatal vitamin or folic acid?	Yes Yes	Unsure Unsure	No	radition				
3	Is your baby enrolled in WIC?	Yes	Unsure	No					
4	In the past month, did you run out of formula for your	No	Breastfeed	Yes					
•	baby?	110	Breastreed	103					
5	In the past year, did you worry that your food would run	Never	Sometimes	Often					
	out before you got money or Food Stamps to buy more?								
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 <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	Yes	Unsure	No					
	(less than 120 degrees)?								
11	If your home has more than one floor, do you have safety	Yes	One floor	No					
	guards on the windows and gates for the stairs?								
12	Does your home have cleaning supplies, medicines and	Yes	Unsure	No					
	matches locked away?								
13	Does your home have the phone number of the Poison	Yes	Unsure	No					
	Control Center (800-222-1222) posted by the phone?								
14	Do you <b>always</b> stay with your baby when s/he is in the	Yes	Unsure	No					
	bathtub?								
15	Do you <b>always</b> place your baby in a rear facing car seat in	Yes	Unsure	No					
	the back seat?								
16	Is the car seat you use the right one for the age and size of	Yes	Unsure	No					
	your baby?								
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 afraid of your partner?	No	No partner	Yes					
19	In the past year, have you thought of getting a court order for	No	No partner	Yes					
	protection?								
20	Has your baby <b>ever</b> witnessed adults in the home hitting,	No	Unsure	Yes					
	slapping, kicking <b>or</b> physically threatening each other?								
21	Has your baby ever lived away from home for more than a	No	Unsure	Yes					
	month?								
22	Do you give your baby a bottle with anything except	No	Unsure	Yes	Dental				
	formula, breast milk or water?								
23	Do you feel your baby is difficult to take care of?	Never	Sometimes	Often	Parenting				
24	Are you currently living with a spouse or partner?	Yes	Unsure	No	Stress				
25	Are your baby's parents separated, divorced, or not living	No	Unsure	Yes					
	together?								
26	Did your baby <b>ever</b> live with anyone who went to prison, jail	No	Unsure	Yes					
	or other correctional facility?								

27	Do you have friends or family who help take care of your baby?	Often	Sor	netimes	Never	
28	Does your family look out for each other, feel close to each other and support each other?	Often	often Sometimes			
29	Over the past <b>2 weeks</b> , 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
	<ul><li>A1. Little interest or pleasure in doing things</li><li>A2. Feeling down, depressed, or hopeless</li><li>B1. Feeling nervous, anxious or on edge</li><li>B2. Not being able to stop or control worrying</li></ul>	0 0 0	1 1 1	2 2 2 2	3 3 3 3	Total Part A: Total Part B:
30	Did your baby <b>ever</b> live with anyone who was depressed, mentally ill or suicidal?	No		nsure	Yes	1000110015
31	Does your baby spend time with anyone who smokes?	No	U	nsure	Yes	Substance
32	On any single occasion, during the past three months, have you had <b>more than 4 drinks</b> containing alcohol?	No	U	nsure	Yes	Exposure
33	Does your baby spend time with anyone who uses drugs or drinks too much alcohol?	No		nsure	Yes	
34	Did your baby <b>ever</b> live with anyone who had a problem with drugs or alcohol?	No		nsure	Yes	
35	Has a family member or contact had tuberculosis disease?	No		nsure	Yes	Tuberculosis
36	Has a family member had a positive tuberculin skin test result?	No		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		nsure	No	Other
40	Are you doing something to keep yourself (or your partner) from getting pregnant?	<ul> <li>□ Yes, IUD or implant</li> <li>□ Yes, permanent (e.g. tubes tivasectomy)</li> <li>□ Yes, other birth control</li> <li>□ No, pregnant</li> <li>□ No, trying to get pregnant</li> <li>□ No</li> </ul>			s tied or	Questions
41	Do you have any other questions or concerns about your	No	U	nsure	Yes	
	baby's health, development, or behavior?					

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

**Whole Child Assessment for Ages 7-12 Months** 

Child's Name (first & last)	Date of Birth	□ Female	Today's Date	In Child/Daycare?	
		□ Male		□ Yes	□ No
Person Completing Form	□ Parent □ Rel	ative □ Frie	end		
	□ Guardian □ Ot	ther (specify)			

chil <b>ans</b>	ase answer all the questions on this form as best you can. It we'ld stay healthy. You may skip any question if you do not know wer. You may add comments to explain your answers. Your a rehild's medical record.	v an ansı	wer or do not want	to	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	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
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 <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	In the past year, have you felt afraid of your partner?	No	No partner	Yes	
21	<b>In the past year</b> , have you thought of getting a court order for protection?	No	No partner	Yes	
22	Has your baby <b>ever</b> witnessed adults in the home hitting, slapping, kicking <b>or</b> physically threatening each other?	No	Unsure	Yes	
23	Has your baby <b>ever</b> lived away from home for more than a month?	No	Unsure	Yes	
24	Do you give your baby a bottle with anything except formula, breast milk or water?	No	Unsure	Yes	Dental
25	Do you feel your baby is difficult to take care of?	Never	Sometimes	Often	Parenting
26	Are you currently living with a spouse or partner?	Yes	Unsure	No	Stress

27	A 1 - 1 - 2	No	Т	Jnsure	Vac	
27	Are your baby's parents separated, divorced, or not living together?	No Onsure			Yes	
28	Did your baby <b>ever</b> live with anyone who went to prison,	No Unsure			Yes	
	jail or other correctional facility?				105	
29	Do you have friends or family who help take care of your		_			
	baby?	Often	So	metimes	Never	
30	Does your family look out for each other, feel close to each	Often	So	metimes	Never	
	other and support each other?					
31	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	T . 1D . A
	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:
32	Did your baby <b>ever</b> live with anyone who was depressed,	No	J	Jnsure	Yes	
	mentally ill or suicidal?					
33	Does your baby spend time with anyone who smokes?	No	J	Jnsure	Yes	Substance
34	On any single occasion, during the past three months, have	No	J	Jnsure	Yes	Exposure
	you had more than 4 drinks containing alcohol?					•
35	Does your baby spend time with anyone who uses drugs or	NT.	т	T	<b>V</b>	
	drinks too much alcohol?	No	Unsure		Yes	
36	Did your baby <b>ever</b> live with anyone who had a problem	No	J	Jnsure	Yes	
	with drugs or alcohol?					
37	Has a family member or contact had tuberculosis disease?	No	J	Jnsure	Yes	Tuberculosis
38	Has a family member had a positive tuberculin skin test	No	J	Jnsure	Yes	Risk
	result?					
39	Was your baby born in a high-risk country (countries other	No	J	Insure	Yes	
	than the United States, Canada, Australia, New Zealand, or					
	Western and North European countries)?					
40	Has your baby traveled (had contact with resident	No	Ţ	Jnsure	Yes	
11	populations) to a high-risk country for more than 1 week?			*		
41	Do you have a high school degree?	Yes		Jnsure	No	Other
42	Are you doing something to keep yourself (or your partner)			r implant	1	Questions
	from getting pregnant?				s tied or	
			sectomy)	oirth control		
		<ul><li>□ No, pregnant</li><li>□ No, trying to get pregna</li></ul>			t .	
				o got prognam	·	
43	Do you have any other questions or concerns about your	No		Insure	Yes	
	baby's health, development, or behavior?					
		·	·			

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments
□ Nutrition					
□ Physical Activity					
□ Sleep					
□ Safety					
□ Dental Health					
□ Parenting Stress					
□ Mental Health					
□ Substances					
□ Tuberculosis					□ Patient Declined SHA
□ Other					
PCP's Signature		I	Print 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	□ Parent □ Rel □ Guardian □ Ot		end		

	se answer all the questions on this form as best you can. It will stay healthy. <b>You may skip any question if you do not know</b>				
	v <b>er.</b> You may add comments to explain your answers. Your an l's medical record.	swers wil	l be protected as pa	ert of your	Clinic Use Only:
1	Do you breastfeed your child?	Yes	Unsure	No	Nutrition
2	Do you take a multivitamin, prenatal vitamin or folic acid?	Yes	Unsure	No	
3	Does your child eat breakfast every day?	Yes	Unsure	No	1
4	Does your child drink or eat 3 servings of calcium-rich	Yes	Unsure	No	
	foods daily, such as formula, breast milk, cheese, yogurt,				
_	soy milk, or tofu?				
5	Does your child eat fruits and vegetables at least two times	Yes	Unsure	No	
	per day?	N.T.	**	***	
6	Does your child eat high fat foods, such as fried foods,	No	Unsure	Yes	
	chips, ice cream, or pizza more than once <b>per week</b> ?		**		
7	Does your child drink <u>more than one</u> small cup (4 - 6 oz.)	No	Unsure	Yes	
	of juice <b>per day</b> ?				
8	Does your child drink soda, juice drinks, sports drinks,	No	Unsure	Yes	
	energy drinks, or other sweetened drinks <u>more than once</u>				
	per week?				
9	Is your child enrolled in WIC?	Yes	Unsure	No	
10	In the past year, did you worry that your food would run	Never	Sometimes	Often	
	out before you got money or Food Stamps to buy more?				
11	Does your child play actively <u>most days</u> of the week?	Yes	Unsure	No	Physical
12	Does your child watch TV or play video games?	No	Unsure	Yes	Activity
13	Are you concerned about your child's weight?	No	Unsure	Yes	
14	Does your child have trouble falling asleep or staying asleep?	Yes	Unsure	No	Sleep
15	Does your home have a working smoke detector?	Yes	Unsure	No	Safety
16	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	Unsure	No	
17	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	
18	Does your home have cleaning supplies, medicines and matches locked away?	Yes	Unsure	No	
19	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by the phone?	Yes	Unsure	No	
20	Do you <b>always</b> stay with your child when s/he is in the bathtub?	Yes	Unsure	No	
21	Do you <b>always</b> place your child in a rear facing car seat in the back seat?	Yes	Unsure	No	
22	Is the car seat you use the right one for the age and size of your child?	Yes	Unsure	No	
23	Do you <b>always</b> 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 <b>always</b> wear a helmet when riding a bike,	Yes	Ι	Doesn't	No	
	skateboard, or scooter?			ride		
27	In the past year, have you felt afraid of your partner?	No	No	partner	Yes	
28	In the past year, have you thought of getting a court order for protection?	No	No partner		Yes	
29	Has your child <b>ever</b> witnessed adults in the home hitting,	No	1	Unsure	Yes	
30	slapping, kicking <b>or</b> physically threatening each other?  Has your child <b>ever</b> lived with a parent or other adult who					
30	often hit, slapped or kicked the child?	No	ı	Unsure	Yes	
31	Has your child <b>ever</b> lived away from home for more than a					
	month?	No	1	Unsure	Yes	
32	Do you help your child brush and floss her/his teeth daily?	Yes	1	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	2400
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?					
38	Did your child <b>ever</b> live with anyone who went to prison,	No	1	Unsure	Yes	
	jail or other correctional facility?					
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	Not at	Several	More than	Nearly	M 4 - 1
	by any of the following problems?	all	days	half the days	every day	Mental 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 <b>ever</b> live with anyone who was depressed, mentally ill or suicidal?	No	l	Unsure	Yes	
43	Does your child spend time with anyone who smokes?	No	ı	Unsure	Yes	Substance
44	On any single occasion, during the past three months, have	No	I	Unsure	Yes	Exposure
	you had more than 4 drinks containing alcohol?					
45	Does your child spend time with anyone who uses drugs or	No	1	Insure	Yes	
10	drinks too much alcohol?					
46	Did your child <b>ever</b> live with anyone who had a problem with drugs or alcohol?	No	\\	Unsure	Yes	
47	Has your child <b>ever</b> been touched, or asked to touch, an	No	No. Lingues		Yes	Sexual
	adult or someone at least 5 years older sexually?	No Unsure			Issues	
48	Has a family member or contact had tuberculosis disease?	No Unsure		Yes	Tuberculosis	
49	Has a family member had a positive tuberculin skin test	No Unsure		Yes	Risk	
50	result?  Was your shild born in a high risk country (countries other	No Unsure		Yes		
30	Was your child born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or	No U		Jusuie	168	
	Western and North European countries)?					
51	Has your child traveled (had contact with resident	No	1	Jnsure	Yes	
	populations) to a high-risk country for more than 1 week?			<del>-</del>		

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

Clinic Use Only	Counseled	Referred	Anticipatory Follow-up C Guidance Ordered		Comments
□ Nutrition					
☐ Physical Activity					
□ Sleep					
□ Safety					
□ Dental Health					
□ Parenting Stress					
□ Mental Health					
□ Substances					
□ Sexual					□ Patient Declined SHA
□ 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	□ Parent □ Rel	ative □ Frie	end		
	□ Guardian □ Ot	her (specify)			

chila	se answer all the questions on this form as best you can. It will stay healthy. <b>You may skip any question if you do not know</b>	an answ	er or do not want to						
answer. You may add comments to explain your answers. Your answers will be protected as part of your child's medical record.									
1	Do you take a multivitamin, prenatal vitamin or folic acid?	Yes	Unsure	No	Only: Nutrition				
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</u> times <b>per day</b> ?	Yes	Unsure	No					
5	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once <b>per week</b> ?	No	Unsure	Yes					
6	Does your child drink more than one 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 more than once per week?	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				
11	Does your child watch TV or play video games less than 2 hours <b>per day</b> ?	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?	Yes	Unsure	No	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 <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	1	Unsure	Yes	
25	Does your child <b>always</b> wear a helmet when riding a bike,	Yes	Ι	Doesn't	No	
	skateboard, or scooter?			ride		
26	In the past year, have you felt afraid of your partner?	No	No	partner	Yes	
27	<b>In the past year</b> , have you thought of getting a court order for protection?	No	No	partner	Yes	
28	Has your child <b>ever</b> witnessed adults in the home hitting, slapping, kicking <b>or</b> physically threatening each other?	No	1	Unsure	Yes	
29	Has your child <b>ever</b> lived with a parent or other adult who <b>often</b> hit, slapped or kicked the child?	No	1	Unsure	Yes	
30	Has your child <b>ever</b> lived away from home for more than a month?	No	1	Unsure	Yes	
31	Do you help your child brush and floss her/his teeth daily?	Yes	1	Unsure	No	Dental
32	Do you feel your child is difficult to take care of?	Never		metimes	Often	Parenting
33	Do you swear at or insult your child?	Never	-	metimes	Often	Stress
34	Do you need to hit/spank your child?	Never		metimes	Often	Buess
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	1	Unsure	Yes	
38	Do you have friends or family who help take care of your child?	Often	So	metimes	Never	
39	Does your family look out for each other, feel close to each other and support each other?	oes your family look out for each other, feel close to				
40	Over the past <b>2 weeks</b> , 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	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	T . 1D . D
41	B2. Not being able to stop or control worrying	0	1	2	3	Total Part B:
41	Did your child <b>ever</b> live with anyone who was depressed, mentally ill or suicidal?	No	1	Unsure	Yes	
42	Does your child spend time with anyone who smokes?	No	1	Unsure	Yes	Substance
43	On any single occasion, during the past three months, have you had <b>more than 4 drinks</b> containing alcohol?	No	1	Unsure	Yes	Exposure
44	Does your child spend time with anyone who uses drugs or drinks too much alcohol?	No	1	Unsure	Yes	
45	Did your child <b>ever</b> live with anyone who had a problem with drugs or alcohol?	No	ı	Unsure	Yes	
46	Has your child <b>ever</b> been touched, or asked to touch, an adult or someone at least 5 years older sexually?	No	1	Unsure	Yes	Sexual Issues
47	Has a family member or contact had tuberculosis disease?	No	1	Unsure	Yes	Tuberculosis
48	Has a family member had a positive tuberculin skin test result?	No		Unsure	Yes	Risk
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	ı	Unsure	Yes	
50	Has your child traveled (had contact with resident	No	1	Unsure	Yes	

51	Do you have a high school degree?	Yes	S	Unsure	No	Other
						Questions
52	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			
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	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments
			Guidance	Ordered	
□ Nutrition					
□ Physical Activity					
□ Sleep					
□ Safety					
□ Dental Health					
□ Parenting Stress					
□ Mental Health					
□ Substances					
□ Sexual					□ Patient Declined SHA
□ Tuberculosis					
□ Other					
PCP's Signature		F	Print Name		Date

**Whole Child Assessment for Ages 5-8 Years** 

THOSE CHILD I LODGED LINE					
Child's Name (first & last)	Date of Birth □ Fe		male	Today's Date	School/Grade in School
		□ Male			
Person Completing Form	□ Parent □ Relative		Schoo	l Attendance	School Grades
	□ Friend □		Regular? □ Yes		□ Average or Better than average
□ Other	Guardian		□ No		☐ Below average or Poor
(specify)					_

chil	ase answer all the questions on this form as best you can. It was d stay healthy. You may skip any question if you do not know your. You may add comments to complain your answers. Your a	v an answ	er or do not want i	to	Clinic Use					
	<b>answer.</b> You may add comments to explain your answers. Your answers will be protected as part of your child's medical record.									
1	Does your child eat breakfast <b>every day</b> ?	Yes	Unsure	No	Only: 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 <b>per day</b> ?	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 <b>per day</b> ?	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 ru 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 <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	In the past year, have you felt afraid of your partner?	No	No partner	Yes						
21	<b>In the past year</b> , have you thought of getting a court order for protection?	No	No partner	Yes						
22	Has your child <b>ever</b> witnessed adults in the home hitting, slapping, 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 <b>often</b> hit, slapped or kicked the child?	No	Ţ	Jnsure	Yes	
24	Does your child have trouble with anger or get into fights with other children?	No	τ	Jnsure	Yes	
25	Has your child <b>ever</b> lived away from home for more than a month?	No	Ţ	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	τ	Jnsure	Yes	
27	Does your child brush and floss her/his teeth daily?	Yes	Ţ	Jnsure	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	Jnsure	No	
32	Are your child's parents separated, divorced, or not living together?	No	τ	Jnsure	Yes	
33	Did your child <b>ever</b> live with anyone who went to prison, jail or other correctional facility?	No	Ţ	Jnsure	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 <b>often</b> seem sad or depressed?	No	Ţ	Jnsure	Yes	M1
37	Over the past <b>2 weeks</b> , 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	0	1	2	3	
	A2. Feeling down, depressed, or hopeless	0	1	2	3	Total Part A:
	B1. Feeling nervous, anxious or on edge	Ö	1	2	3	T . 1D . D
	B2. Not being able to stop or control worrying	0	1	2	3	Total Part B
38	Did your child <b>ever</b> live with anyone who was depressed, mentally ill or suicidal?	No	Ţ	Insure	Yes	
39	Does your child spend time with anyone who smokes?	No	Ţ	Jnsure	Yes	Substance
40	On any single occasion, during the past three months, have you had <b>more than 4 drinks</b> containing alcohol?	No	τ	Jnsure	Yes	Exposure
41	Does your child spend time with anyone who uses drugs or drinks too much alcohol?	No	Ţ	Jnsure	Yes	
42	Did your child <b>ever</b> live with anyone who had a problem with drugs or alcohol?	No	J	Jnsure	Yes	
43	Has your child <b>ever</b> been touched, or asked to touch, an adult or someone at least 5 years older sexually?	No	τ	Jnsure	Yes	Sexual Issues
44	Has a family member or contact had tuberculosis disease?	No	Ţ	Unsure	Yes	Tuberculosis
45	Has a family member had a positive tuberculin skin test result?	No	J	Jnsure	Yes	Risk
46	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	Ţ	Jnsure	Yes	
47	Has your child traveled (had contact with resident populations) to a high-risk country for more than 1 week?	No	Ţ	Jnsure	Yes	

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

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

Whole Child Assessment for Ages 9-11 Years

THE CITE OF THE PROPERTY.					
Child's Name (first & last)	Date of Birth	□ Female		Today's Date	School/Grade in School
		□ Male			
Person Completing Form	□ Parent □ Relative		Schoo	l Attendance	School Grades
	□ Friend □		Regular? □ Yes		□ Average or Better than average
□ Other Guardian			□ No	□ Below average or Poor	
(specify)					_

chil	ase answer all the questions on this form as best you can. It weld stay healthy. You may skip any question if you do not know war. You may add comments to explain your answers. Your a	v an answ	er or do not want to	)	Clinic Use			
answer. You may add comments to explain your answers. Your answers will be protected as part of your child's medical record.								
1	Does your child eat breakfast <b>every day</b> ?	Yes	Unsure	No	Only: Nutrition			
2	Does your child drink or eat 3 servings of calcium-rich	Yes	Unsure	No	-			
3	foods daily, such as milk, cheese, yogurt, soy milk, or tofu?  Does your child eat fruits and vegetables at least 2 times	Yes	Unsure	No	-			
	per day?				_			
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 more than one cup (8 oz.) of juice per day?	No	Unsure	Yes	-			
6	Does your child drink soda, juice, sports drinks, energy drinks, or other sweetened drinks more than once <b>per week</b> ?	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 most days 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	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	1			
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	In the past year, have you felt afraid of your partner?	No	No partner	Yes				
20	In the past year, have you thought of getting a court order for protection?	No	No partner	Yes				
21	Has your child <b>ever</b> witnessed adults in the home hitting, slapping, 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 <b>often</b> hit, slapped or kicked 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 <b>ever</b> lived away from home for more than a month?	No	Ţ	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	No Unsure			
26	Does your child brush and floss her/his teeth daily?	Yes	Ţ	Unsure	No	Dental
27	Do you feel your child is difficult to take care of?	Never	So	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	
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	ı	Unsure	Yes	
32	Did your child <b>ever</b> live with anyone who went to prison, jail or other correctional facility?	No	τ	Unsure	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 <b>often</b> seem sad or depressed?	No	U	Unsure	Yes	Marital
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	Health
	A1. Little interest or pleasure in doing things	0				
	A2. Feeling down, depressed, or hopeless	0	1	2	3	Total Part A:
	B1. Feeling nervous, anxious or on edge	0	1 1	2 2	3	Total Fart A.
	B2. Not being able to stop or control worrying	0	$\begin{bmatrix} 1 \\ 1 \end{bmatrix}$ $\begin{bmatrix} 2 \\ 2 \end{bmatrix}$		3 3	Total Part B
37	Did your child <b>ever</b> live with anyone who was depressed,	No	Unsure		Yes	
3,	mentally ill or suicidal?	110	,		105	
38	Does your child spend time with anyone who smokes?	No	Ţ	Jnsure	Yes	Substances
39	Has your child ever smoked cigarettes or chewed tobacco?	No	Ţ	Unsure	Yes	
40	Are you concerned your child may be using drugs or sniffing substances, such as glue, to get high?	No	Ţ	Jnsure	Yes	
41	Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?	No	Ţ	Unsure	Yes	
42	On any single occasion, during the past three months, have you had <b>more than 4 drinks</b> containing alcohol?	No	Ţ	Insure	Yes	
43	Does your child spend time with anyone who uses drugs or drinks too much alcohol?	No	ī	Unsure	Yes	
44	Did your child <b>ever</b> live with anyone who had a problem with drugs or alcohol?	No	Ţ	Unsure	Yes	
45	Has your child started dating or "going out" with boyfriends or girlfriends?	No	Unsure		Yes	Sexual Issues
46	Do you think your child might be sexually active?	No	Unsure		Yes	
47	Has your child <b>ever</b> been touched, or asked to touch, an	No	Unsure		Yes	
	adult or someone at least 5 years older sexually?					
48	Has a family member or contact had tuberculosis disease?	No	o Unsure		Yes	Tuberculosis Risk
49	Has a family member had a positive tuberculin skin test result?	No	ı	Unsure	Yes	
50	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	Ţ	Unsure	Yes	
	" obtain and rearm European countries):		<u> </u>			

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

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

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

Name (first & last)	Date of Birth	□ Female	Today's Date	School/Grade	School Attendance
		□ Male			Regular?   Yes
					□ No
IF YOU NEED ASSISTANCE C	COMPLETING TH	School Grades			
INDICATE WHO ASSISTED:		☐ Average or Better than	average		
□ Parent □ Relative □ Frie	nd 🗆 Guardian 🛚	☐ Below average or Poor	•		

stay	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 an are add comments to explain your answers. Your answers will be bord.	nswer or	do not want to answ	ver. You	Clinic Use Only:
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 more than once <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	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 <b>per day</b> ?	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 <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 <b>ever</b> witnessed adults in the home hitting, slapping, kicking <b>or</b> 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	No	U	nsure	Yes	
	anyone (or have you hurt anyone) in the <b>past year</b> ?					
24	Have you <b>ever</b> 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 Unsure			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 <b>ever</b> 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	2 2	3 3	Total Part A:
	B1. Feeling nervous, anxious or on edge	0			3	
	B2. Not being able to stop or control worrying	0	1	2	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	<b>T</b> 1		Vac	
	too much alcohol?	No	U	nsure	Yes	
41	Did you <b>ever</b> 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 <b>ever</b> 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	

		ı		ı	
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.?	110	Chiane		
	b. Have you or your partner(s) had sex with other people in	No	Unsure	Yes	
	the past year?		0 0		
	c. Have you or your partner(s) had sex without using birth	No	Unsure	Yes	
	control in the past year?				
	d. The last time you had sex, did you use birth control?	No	Unsure	Yes	
	e. Have you or your partner(s) had sex without a condom			37	
	in the past year?	No	Unsure	Yes	
	f. Did you or your partner use a condom the last time you		**	Yes	
	had sex?	No	Unsure	168	
46	Do you have any questions about your sexual orientation	No	Unsure	Yes	
	(who you are attracted to) or gender identity (how you feel as				
	a boy, girl, or other gender)?				
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	No	Unsure	Yes	
	result?				
49	Were you born in a high-risk country (countries other than	No	Unsure	Yes	
	the United States, Canada, Australia, New Zealand, or				
	Western and North European countries)?				
50	Have you traveled (had contact with resident populations) to	No	Unsure	Yes	
	a high-risk country for more than 1 week?				
51	Does your primary caregiver (parent or guardian) have a	Yes	Unsure	No	Other
	high school degree?				Questions
52	Do you have any other questions or concerns about your	No	Unsure	Yes	2000000
	health? If yes, please describe				
1	neardi. If jes, piease describe	l		I	

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