Whole Child Assessment for Ages 0-6 Months

Child's Name (first & last)	Date of Birth	□ Female □ Male	Today's Date	In Child/Daycare? □ Yes □ No
Person Completing Form	□ Parent □ Relative □ Friend □ Guardian □ Other (specify)			

	Please answer all the questions on this form as best you can. It will help us know how we can help your child stay 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. Your answers will be protected as part of your child's medical record.*				***Clinic Use Only:***
1	Do you breastfeed your baby?	Yes	Unsure	No	Nutrition
2	Do you take a multivitamin, prenatal vitamin or folic acid?	Yes	Unsure	No	
3	Is your baby enrolled in WIC?	Yes	Unsure	No	
4	**In the past month**, did you run out of formula for your baby?	No	Breastfeed	Yes	
5	**In the past year,** did you worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often	
6	Are you concerned about your baby's weight?	No	Unsure	Yes	Physical Activity
7	Does your baby watch any TV?	No	Unsure	Yes	
8	Do you **always** put your baby to sleep on his/her back?	Yes	Unsure	No	Sleep
9	Does your home have a working smoke detector?	Yes	Unsure	No	Safety
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	Unsure	No	
11	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	One floor	No	
12	Does your home have cleaning supplies, medicines and matches locked away?	Yes	Unsure	No	
13	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by the phone?	Yes	Unsure	No	
14	Do you **always** stay with your baby when s/he is in the bathtub?	Yes	Unsure	No	
15	Do you **always** place your baby in a rear facing car seat in the back seat?	Yes	Unsure	No	
16	Is the car seat you use the right one for the age and size of your baby?	Yes	Unsure	No	
17	Does your baby spend time in a home where a gun is kept?	No	Unsure	Yes	
18	In the past year, have you felt afraid of your partner?	No	No partner	Yes	
19	In the past year, have you thought of getting a court order for protection?	No	No partner	Yes	
20	Has your baby **ever** witnessed adults in the home hitting, slapping, kicking **or** physically threatening each other?	No	Unsure	Yes	
21	Has your baby ever lived away from home for more than a month?	No	Unsure	Yes	
22	Do you give your baby a bottle with anything except formula, breast milk or water?	No	Unsure	Yes	Dental
23	Do you feel your baby is difficult to take care of?	Never	Sometimes	Often	Parenting Stress
24	Are you currently living with a spouse or partner?	Yes	Unsure	No	
25	Are your baby's parents separated, divorced, or not living together?	No	Unsure	Yes	
26	Did your baby **ever** live with anyone who went to prison, jail or other correctional facility?	No	Unsure	Yes	

#	Question					
27	Do you have friends or family who help take care of your baby?	Often	Sometimes		Never	
28	Does your family look out for each other, feel close to each other and support each other?	Often	Sometimes		Never	
29	Over the past **2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	Mental Health
	A1. Little interest or pleasure in doing things	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:
30	Did your baby **ever** live with anyone who was depressed, mentally ill or suicidal?	No	Unsure		Yes	
31	Does your baby spend time with anyone who smokes?	No	Unsure		Yes	Substance Exposure
32	On any single occasion, during the past three months, have you had **more than 4 drinks** containing alcohol?	No	Unsure		Yes	
33	Does your baby spend time with anyone who uses drugs or drinks too much alcohol?	No	Unsure		Yes	
34	Did your baby **ever** 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?	□ Yes, IUD or implant □ Yes, permanent (e.g. tubes tied or vasectomy) □ Yes, other birth control □ No, pregnant □ No, trying to get pregnant □ 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:

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	Print Name	Date

Whole Child Assessment for Ages 7-12 Months

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Daycare? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (specify)			

Please answer all the questions on this form as best you can. It will help us know how we can help your child stay 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. Your answers will be protected as part of your child's medical record.*					***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	**In the past month**, did you run out of formula for your baby?	No	Breastfeed	Yes	
6	**In the past year,** did you worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often	
7	Are you concerned about your baby's weight?	No	Unsure	Yes	Physical Activity
8	Does your baby watch any TV?	No	Unsure	Yes	
9	Do you **always** put your baby to sleep on his/her back?	Yes	Unsure	No	Sleep
10	Does your home have a working smoke detector?	Yes	Unsure	No	Safety
11	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	Unsure	No	
12	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	One floor	No	
13	Does your home have cleaning supplies, medicines and matches locked away?	Yes	Unsure	No	
14	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by the phone?	Yes	Unsure	No	
15	Do you **always** stay with your child when s/he is in the bathtub?	Yes	Unsure	No	
16	Do you **always** place your child in a rear facing car seat in the back seat?	Yes	Unsure	No	
17	Is the car seat you use the right one for the age and size of your baby?	Yes	Unsure	No	
18	Does your baby spend time near a swimming pool, river, or lake?	No	Unsure	Yes	
19	Does your baby spend time in a home where a gun is kept?	No	Unsure	Yes	
20	**In the past year**, have you felt afraid of your partner?	No	No partner	Yes	
21	**In the past year**, have you thought of getting a court order for protection?	No	No partner	Yes	
22	Has your baby **ever** witnessed adults in the home hitting, slapping, kicking **or** physically threatening each other?	No	Unsure	Yes	
23	Has your baby **ever** 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 Stress
26	Are you currently living with a spouse or partner?	Yes	Unsure	No	

#	Question					Category
27	Are your baby's parents separated, divorced, or not living together?	No	Unsure		Yes	
28	Did your baby **ever** live with anyone who went to prison, jail or other correctional facility?	No	Unsure		Yes	
29	Do you have friends or family who help take care of your baby?	Often	Sometimes		Never	
30	Does your family look out for each other, feel close to each other and support each other?	Often	Sometimes		Never	
31	Over the past **2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	Mental Health
	A1. Little interest or pleasure in doing things	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:
32	Did your baby **ever** live with anyone who was depressed, mentally ill or suicidal?	No	Unsure		Yes	
33	Does your baby spend time with anyone who smokes?	No	Unsure		Yes	Substance Exposure
34	On any single occasion, during the past three months, have you had **more than 4 drinks** containing alcohol?	No	Unsure		Yes	
35	Does your baby spend time with anyone who uses drugs or drinks too much alcohol?	No	Unsure		Yes	
36	Did your baby **ever** 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?	□ Yes, IUD or implant □ Yes, permanent (e.g. tubes tied or vasectomy) □ Yes, other birth control □ No, pregnant □ No, trying to get pregnant □ 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:

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	Print Name				Date

Whole Child Assessment for Ages 1 – 2 Years

Child's Name (first & last)	Date of Birth	□ Female □ Male	Today's Date	In Child/Daycare? □ Yes □ No
Person Completing Form	□ Parent □ Relative □ Friend □ Guardian □ Other (specify)			

Please answer all the questions on this form as best you can. It will help us know how we can help your child stay 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. Your answers will be protected as part of your child's medical record.*					***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	
4	Does your child drink or eat 3 servings of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or tofu?	Yes	Unsure	No	
5	Does your child eat fruits and vegetables at least two times **per day**?	Yes	Unsure	No	
6	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once **per week**?	No	Unsure	Yes	
7	Does your child drink more than one small cup (4 - 6 oz.) of juice **per day**?	No	Unsure	Yes	
8	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once **per week**?	No	Unsure	Yes	
9	Is your child enrolled in WIC?	Yes	Unsure	No	
10	**In the past year,** did you worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often	
11	Does your child play actively most days of the week?	Yes	Unsure	No	Physical Activity
12	Does your child watch TV or play video games?	No	Unsure	Yes	
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 **always** stay with your child when s/he is in the bathtub?	Yes	Unsure	No	
21	Do you **always** 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 **always** check for children before backing your car out?	Yes	Unsure	No	

#	Question				Category
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 **always** wear a helmet when riding a bike, skateboard, or scooter?	Yes	Doesn't ride	No	
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 **ever** witnessed adults in the home hitting, slapping, kicking **or** physically threatening each other?	No	Unsure	Yes	
30	Has your child **ever** lived with a parent or other adult who **often** hit, slapped or kicked the child?	No	Unsure	Yes	
31	Has your child **ever** 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 **ever** 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	

#	Question	Not at all	Several days	More than half the days	Nearly every day	Category
41	Over the past **2 weeks**, how often have you been bothered by any of the following problems?					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:

#	Question				Category
42	Did your child **ever** 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	On any single occasion, during the past three months, have you had **more than 4 drinks** containing alcohol?	No	Unsure	Yes	
45	Does your child spend time with anyone who uses drugs or drinks too much alcohol?	No	Unsure	Yes	
46	Did your child **ever** live with anyone who had a problem with drugs or alcohol?	No	Unsure	Yes	
47	Has your child **ever** been touched, or asked to touch, an adult or someone at least 5 years older sexually?	No	Unsure	Yes	Sexual Issues
48	Has a family member or contact had tuberculosis disease?	No	Unsure	Yes	Tuberculosis Risk
49	Has a family member had a positive tuberculin skin test result?	No	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	Unsure	Yes	
51	Has your child traveled (had contact with resident populations) to a high-risk country for more than 1 week?	No	Unsure	Yes	

52	Do you have a high school degree?	Yes	Unsure	No	Other Questions
53	Are you doing something to keep yourself (or your partner) from getting pregnant?	□ Yes, IUD or implant □ Yes, permanent (e.g. tubes tied or vasectomy) □ Yes, other birth control □ No, pregnant □ No, trying to get pregnant □ No			
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	

If yes, please describe:

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

Whole Child Assessment for Ages 3 – 4 Years

Child's Name (first & last)	Date of Birth	□ Female □ Male	Today's Date	In Child/Daycare? □ Yes □ No
Person Completing Form	□ Parent □ Relative □ Friend □ Guardian □ Other (specify)			

	Please answer all the questions on this form as best you can. It will help us know how we can help your child stay 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. Your answers will be protected as part of your child's medical record.*				***Clinic Use Only:***
1	Do you take a multivitamin, prenatal vitamin or folic acid?	Yes	Unsure	No	Nutrition
2	Does your child eat breakfast **every day**?	Yes	Unsure	No	
3	Does your child drink or eat <u>3 servings</u> of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or tofu?	Yes	Unsure	No	
4	Does your child eat fruits and vegetables <u>at least two</u> times **per day**?	Yes	Unsure	No	
5	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza <u>more than once</u> **per week**?	No	Unsure	Yes	
6	Does your child drink <u>more than one</u> small cup (4 - 6 oz.) of juice **per day**?	No	Unsure	Yes	
7	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks <u>more than once</u> **per week**?	No	Unsure	Yes	
8	Is your child enrolled in WIC?	Yes	Unsure	No	
9	**In the past year,** did you worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often	
10	Does your child play actively <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</u> **per day**?	Yes	Unsure	No	
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 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 **always** stay with your child when s/he is in the bathtub?	Yes	Unsure	No	
20	Do you **always** place your child in a forward facing car seat in the back seat?	Yes	Unsure	No	
21	Is the car seat you use the right one for the age and size of your child?	Yes	Unsure	No	
22	Do you always check for children before backing your car out?	Yes	Unsure	No	
23	Does your child spend time near a swimming pool, river, or lake?	No	Unsure	Yes	

#	Question					Category
24	Does your child spend time in a home where a gun is kept?	No	Unsure		Yes	
25	Does your child **always** wear a helmet when riding a bike, skateboard, or scooter?	Yes	Doesn't ride		No	
26	**In the past year**, have you felt afraid of your partner?	No	No partner		Yes	
27	**In the past year**, have you thought of getting a court order for protection?	No	No partner		Yes	
28	Has your child **ever** witnessed adults in the home hitting, slapping, kicking **or** physically threatening each other?	No	Unsure		Yes	
29	Has your child **ever** lived with a parent or other adult who **often** hit, slapped or kicked the child?	No	Unsure		Yes	
30	Has your child **ever** 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 **ever** 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 **2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	Mental Health
	A1. Little interest or pleasure in doing things	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:
41	Did your child **ever** 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	On any single occasion, during the past three months, have you had **more than 4 drinks** containing alcohol?	No	Unsure		Yes	
44	Does your child spend time with anyone who uses drugs or drinks too much alcohol?	No	Unsure		Yes	
45	Did your child **ever** live with anyone who had a problem with drugs or alcohol?	No	Unsure		Yes	
46	Has your child **ever** been 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?	□ Yes, IUD or implant □ Yes, permanent (e.g. tubes tied or vasectomy) □ Yes, other birth control □ No, pregnant □ No, trying to get pregnant □ No			
53	Do you have concerns about how your child speaks?	No	Unsure	Yes	
54	Do you have any other questions or concerns about your child's health, development, or behavior?	No	Unsure	Yes	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments
□ Nutrition	□	□	□	□	
□ Physical Activity	□	□	□	□	
□ Sleep	□	□	□	□	
□ Safety	□	□	□	□	
□ Dental Health	□	□	□	□	
□ Parenting Stress	□	□	□	□	
□ Mental Health	□	□	□	□	
□ Substances	□	□	□	□	
□ Sexual	□	□	□	□	□ Patient Declined SHA
□ Tuberculosis	□	□	□	□	
□ Other	□	□	□	□	

PCP's Signature	Print Name	Date

Whole Child Assessment for Ages 5-8 Years

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

	Please answer all the questions on this form as best you can. It will help us know how we can help your child stay 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. Your answers will be protected as part of your child's medical record.*				***Clinic Use Only:***
1	Does your child eat breakfast **every day**?	Yes	Unsure	No	Nutrition
2	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	Unsure	No	
3	Does your child eat fruits and vegetables at least 2 times **per day**?	Yes	Unsure	No	
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 small cup (4 - 6 oz.) of juice **per day**?	No	Unsure	Yes	
6	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once **per week**?	No	Unsure	Yes	
7	**In the past year,** did you worry that your food would ru 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	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	Unsure	No	
14	Does your home have the phone number of the Poison Control Center (800-222-1222) posted?	Yes	Unsure	No	
15	Do you **always** place your child in a booster seat in the back seat (or use a seat belt if your child is over 4'9")?	Yes	Unsure	No	
16	Does your child spend time near a swimming pool, river, or lake?	No	Unsure	Yes	
17	Does your child spend time in a home where a gun is kept?	No	Unsure	Yes	
18	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Unsure	Yes	
19	Does your child **always** wear a helmet when riding a bike, skateboard, or scooter?	Yes	Doesn't ride	No	
20	**In the past year**, have you felt afraid of your partner?	No	No partner	Yes	
21	**In the past year**, have you thought of getting a court order for protection?	No	No partner	Yes	
22	Has your child **ever** witnessed adults in the home hitting, slapping, kicking **or** physically threatening each other?	No	Unsure	Yes	

#	Question					Category
23	Has your child **ever** lived with a parent or other adult who **often** hit, slapped or kicked 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 **ever** lived away from home for more than a month?	No	Unsure		Yes	
26	Has your child **ever** 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 **ever** 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 **often** seem sad or depressed?	No	Unsure		Yes	Mental Health
37	Over the past **2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	
	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
38	Did your child **ever** live with anyone who was depressed, mentally ill or suicidal?	No	Unsure		Yes	
39	Does your child spend time with anyone who smokes?	No	Unsure		Yes	Substance Exposure
40	On any single occasion, during the past three months, have you had **more than 4 drinks** containing alcohol?	No	Unsure		Yes	
41	Does your child spend time with anyone who uses drugs or drinks too much alcohol?	No	Unsure		Yes	
42	Did your child **ever** live with anyone who had a problem with drugs or alcohol?	No	Unsure		Yes	
43	Has your child **ever** been touched, or asked to touch, an adult or someone at least 5 years older sexually?	No	Unsure		Yes	Sexual Issues
44	Has a family member or contact had tuberculosis disease?	No	Unsure		Yes	Tuberculosis Risk
45	Has a family member had a positive tuberculin skin test result?	No	Unsure		Yes	
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	Unsure		Yes	
47	Has your child traveled (had contact with resident populations) to a high-risk country for more than 1 week?	No	Unsure		Yes	

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

If yes, please describe:

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		Print Name			Date

Whole Child Assessment for Ages 9-11 Years

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

	Please answer all the questions on this form as best you can. It will help us know how we can help your child stay 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. Your answers will be protected as part of your child's medical record.*				***Clinic Use Only:***
1	Does your child eat breakfast **every day**?	Yes	Unsure	No	Nutrition
2	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	Unsure	No	
3	Does your child eat fruits and vegetables at least 2 times **per day**?	Yes	Unsure	No	
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 **per week**?	No	Unsure	Yes	
7	**In the past year,** did you worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often	
8	Does your child exercise or play sports 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 **always** use a seat belt in the back seat (or use a booster seat if under 4'9")?	Yes	Unsure	No	
15	Does your child spend time near a swimming pool, river, or lake?	No	Unsure	Yes	
16	Does your child spend time in a home where a gun is kept?	No	Unsure	Yes	
17	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Unsure	Yes	
18	Does your child **always** wear a helmet when riding a bike, skateboard, or scooter?	Yes	Doesn't ride	No	
19	**In the past year**, have you felt 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 **ever** witnessed adults in the home hitting, slapping, kicking **or** physically threatening each other?	No	Unsure	Yes	
22	Has your child **ever** lived with a parent or other adult who **often** hit, slapped or kicked the child?	No	Unsure	Yes	

#	Question					Category
23	Does your child have trouble with anger or get into fights with other children?	No	Unsure		Yes	
24	Has your child **ever** lived away from home for more than a month?	No	Unsure		Yes	
25	Has your child **ever** been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Unsure		Yes	
26	Does your child brush and floss her/his teeth daily?	Yes	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 **ever** 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 **often** seem sad or depressed?	No	Unsure		Yes	Mental Health
36	Over the past **2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	
	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
37	Did your child **ever** live with anyone who was depressed, mentally ill or suicidal?	No	Unsure		Yes	
38	Does your child spend time with anyone who smokes?	No	Unsure		Yes	Substances
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	On any single occasion, during the past three months, have you had **more than 4 drinks** containing alcohol?	No	Unsure		Yes	
43	Does your child spend time with anyone who uses drugs or drinks too much alcohol?	No	Unsure		Yes	
44	Did your child **ever** live with anyone who had a problem with drugs or alcohol?	No	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 **ever** been touched, or asked to touch, an adult or someone at least 5 years older sexually?	No	Unsure		Yes	
48	Has a family member or contact had tuberculosis disease?	No	Unsure		Yes	Tuberculosis Risk
49	Has a family member had a positive tuberculin skin test result?	No	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	Unsure		Yes	

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

If yes, please describe:

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		Print Name			Date

Whole Child Assessment for Ages 12-17 Years

To Be Completed by Patient

Name (first & last)	Date of Birth	□ Female □ Male	Today's Date	School/Grade	School Attendance Regular? □ Yes □ No
IF YOU NEED ASSISTANCE COMPLETING THIS FORM, PLEASE INDICATE WHO ASSISTED: □ Parent □ Relative □ Friend □ Guardian □ Other (specify)				School Grades □ Average or Better than average □ Below average or Poor	

Please answer all the questions on this form as best you can. It will help us know how we can help you stay 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. Your answers will be protected as part of your medical record.*					***Clinic Use Only:***
1	Do you eat breakfast **every day**?	Yes	Unsure	No	Nutrition
2	Do you drink or eat 3 servings of calcium-rich foods **daily**, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	Unsure	No	
3	Do you eat fruits and vegetables at least 2 times **per day**?	Yes	Unsure	No	
4	Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once **per week**?	No	Unsure	Yes	
5	Do you drink more than 12 oz. (1 soda can) **per day** of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Unsure	Yes	
6	**In the past year,** did you or your family worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often	
7	Do you exercise or play sports most days of the week?	Yes	Unsure	No	Physical Activity
8	Do you watch TV or play video games **less** than 2 hours **per day**?	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 **always** wear a seat belt when riding in a car?	Yes	Unsure	No	
14	Do you spend time in a home where a gun is kept?	No	Unsure	Yes	
15	Do you spend time with anyone who carries a gun, knife, or other weapon?	No	Unsure	Yes	
16	Do you **always** wear a helmet when riding a bike, skateboard, or scooter?	Yes	Don't ride	No	
17	In the **past year**, have you felt afraid of someone you were dating?	No	Not dating	Yes	
18	Have you **ever** witnessed adults in the home hitting, slapping, kicking **or** physically threatening each other?	No	Unsure	Yes	
19	Did you **ever** live with anyone who **often** shouted or yelled at you?	No	Unsure	Yes	
20	Did you **ever** live with anyone who acted in a way that made you feel afraid?	No	Unsure	Yes	
21	Did a parent or other adult **ever** hit you so hard that you had marks or were injured?	No	Unsure	Yes	
22	Have you **ever** lived away from home for more than a month?	No	Unsure	Yes	

#	Question					Category
23	Have you been hit, slapped, kicked, or physically hurt by anyone (or have you hurt anyone) in the **past year**?	No	Unsure		Yes	
24	Have you **ever** 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 **ever** 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 **ever** live with anyone who was depressed, mentally ill or suicidal?	No	Unsure		Yes	Mental Health
31	Over the past **2 weeks**, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	
	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
32	During the past 3 months, have you thought of killing yourself?	No	Unsure		Yes	
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 **ever** 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 **ever** 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	*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, Gonorrhea, genital warts, etc.?	No	Unsure	Yes	
	b. Have you or your partner(s) had sex with other people in the past year?	No	Unsure	Yes	
	c. Have you or your partner(s) had sex without using birth control in the past year?	No	Unsure	Yes	
	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 in the past year?	No	Unsure	Yes	
	f. Did you or your partner use a condom the last time you had sex?	No	Unsure	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:

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		Print Name			Date