Staying Healthy Assessment

5 – 8 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	Grade in School?
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			School Attendance Regular? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	Nutrition
2	Does your child eat fruits and vegetables at least two times per day?	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes	Skip	
4	Does your child drink more than one small cup (4 - 6 oz.) of juice per day?	No	Yes	Skip	
5	Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes	Skip	
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	Physical Activity
7	Are you concerned about your child's weight?	No	Yes	Skip	
8	Does your child watch TV or play video games less than 2 hours per day?	Yes	No	Skip	
9	Does your home have a working smoke detector?	Yes	No	Skip	Safety
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
11	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
12	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	No	Skip	
13	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
14	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	

15	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
16	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
17	Has your child ever witnessed or been victim of abuse or violence?	No	Yes	Skip	
18	Has your child been hit or hit someone in the past year?	No	Yes	Skip	
19	Has your child ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
20	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
21	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
22	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
23	Do you have any other questions or concerns about your child's health or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature	Print Name:	Date:

SHA ANNUAL REVIEW

PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date:
PCP's Signature	Print Name:	Date: