Staying Healthy Assessment

5 - 8 Years

Child's Name (first & last) Date of Birth		Female Today's Date		Grac	Grade in School?			
	·		☐ Male					
Person Completing Form Parent Relative Friend		d 🗌 Gua	ardian		School Attendance			
Other (Specify) Regu							ular? 🗌 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 Need Interpreter? Yes \sum No							
about anything on this form. Your answers will be protected as part of your medical record.							Clinic Use Only:	
1	Does your child drink or eat daily, such as milk, cheese, y	Yes	No	Skip	Nutrition			
2	Does your child eat fruits and per day?	Yes	No	Skip				
3	Does your child eat high fat ice cream, or pizza more than	No	Yes	Skip				
4	Does your child drink more t juice per day?	No	Yes	Skip				
5	Does your child drink soda, j energy drinks, or other sweet week?	No	Yes	Skip				
6	Does your child exercise or pweek?	Yes	No	Skip	Physical Activity			
7	Are you concerned about you	No	Yes	Skip				
8	Does your child watch TV or hours per day?	Yes	No	Skip				
9	Does your home have a work	king smoke detecto	or?	Yes	No	Skip	Safety	
10	Have you turned your water (less than 120 degrees)?	Yes	No	Skip				
11	Does your home have the ph Control Center (800-222-122	Yes	No	Skip				
12	Do you always place your ch seat (or use a seat belt if you			Yes	No	Skip		
13	Does your child spend time I lake?	near a swimming p	oool, river, or	No	Yes	Skip		
14	Does your child spend time i	n a home where a	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	Comments:			
Nutrition								
Physical Activity								
Safety								
☐ Dental Health								
Tobacco Exposure					☐ Patient Declined the SHA			
PCP's Signature	Print Name:			Date:				
SHA ANNUAL REVIEW								
PCP's Signature		Print Name:			Date:			
PCP's Signature			int Name:		Date:			
			ine realise.		Sate.			
PCP's Signature		Print Name:			Date:			