Staying Healthy Assessment

7 - 12 Months

Child's Name (first & last)		Date of Birth Female Male		Today's Date		e Ir	In Child/Day Care?	
Person Completing Form Parent Relative F Other (Specify)				riend Guardian Ne			eed Help with Form?] Yes 🔲 No	
Please answer all the questions on this form as best you can. Circle "Skip answer or do not wish to answer. Be sure to talk to the doctor if you hav anything on this form. Your answers will be protected as part of your m				e quest	ions abc	Need Interpreter?		
1	Do you breastfeed your baby?	Yes	No	Skip	Nutrition			
2	Does your baby drink or eat 3 ser- daily, such as formula, breast mill or tofu?	Yes	No	Skip				
3	Are you concerned about your bal		No	Yes	Skip	Physical Activity		
4	Does your baby watch any TV?		No	Yes	Skip			
5	Does your home have a working s		Yes	No	Skip	Safety		
6	Have you turned your water temperature down to low-warm (less than 120 degrees)?				No	Skip		
7	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?				No	Skip		
8	Does your home have cleaning su matches locked away?	Yes	No	Skip				
9	Does your home have the phone r Control Center (800-222-1222) pe		Yes	No	Skip			
10	Do you always put your baby to s	Yes	No	Skip				

11	Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Skip	
12	Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Skip	
13	Is the car seat you use the right one for the age and size of your baby?	Yes	No	Skip	
14	Does your baby spend time near a swimming pool, river, or lake?	No	Yes	Skip	
15	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
16	Do you give your baby a bottle with anything except formula, breast milk, or water?	No	Yes	Skip	Dental Health
17	Does your baby spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
18	Do you have any other questions or concerns about your baby's health, development 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 Nam	e:		Date: