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: