

**“STAYING HEALTHY” ASSESSMENT  
Children, 4-8 years of age**

<b>Patient Stamp</b>	
Patient Number _____	Plan Name/Number _____
<i>If patient stamp not used, write in Patient and Plan Name/Number</i>	

Child's name (first, last)	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Today's date	<i>For Clinical Use</i>
Your name	Relationship to child <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other			Assistance needed: Reading: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No

*You and your child's health care team can work together towards better health. Please answer these questions as best you can. You may check (✓) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your child's medical record.*

Annual Review Date/Initials

*Sample Question and Answer: Does your child play sports?*       Yes     No     Skip

Interventions Code/Date/Initials
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	<b>Does Your Home Have:</b>		
1.	A working smoke detector?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skip	
2.	Water that comes from the faucet hot enough to burn your child?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
3.	Window guards above the first floor?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skip	
4.	Cleaning supplies, medicines, and matches in a locked cabinet?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skip	
5.	Syrup of Ipecac (the medicine used to cause vomiting) and the Poison Control phone number for emergencies?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skip	
	<b>Does Your Child:</b>		
6.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
7.	See the dentist at least once a year?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skip	
8.	Drink milk or eat yogurt or cheese at least 2 times each day?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skip	
9.	Eat at least 5 servings of fruits or vegetables each day?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skip	
10.	Eat only a limited amount of fried or fast foods?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skip	

<i>For Clinical Use</i>	
Intervention Codes:    C: Counseling    EM: Educational Materials    R: Referral    F: Follow-up Needed    SPN: See Progress Notes	

				<i>For Clinical Use</i>		
				Interventions Code/Date/Initials		
<b>Does Your Child:</b>						
11.	Play actively 5 days a week?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip		
12.	Need to lose or gain weight?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip		
13.	Ever play in the street or unsupervised in the front yard?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip		
14.	Always wear a seat belt when riding in a car?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip		
15.	Always wear a helmet when riding a bike or skateboard?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip		
16.	Spend time at a house or apartment complex with a swimming pool or hot tub?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip		
17.	Spend time in a home where a gun is kept?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip		
18.	Spend time in a home with anyone who smokes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip		
19.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip		
<b>Has Your Child:</b>						
20.	Ever witnessed or been a victim of abuse or violence?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip		
21.	Had any problems at home or school?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip		
22.	<b>Do you have other questions or concerns about your child's health?</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip		
	(Please identify) _____					
	_____					
	_____					
	_____					

*For Clinical Use*

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**Privacy Statement**

The Information Practices Act of 1977 (California Civil Code 1798) and the Federal Privacy Act (5 USC 552a, Subdivision (E)(3)) require this notice to be provided when collecting personal information from individuals. The information on this form is requested by your health care provider, health plan, and the Department of Health Services for purposes of providing health education services. Furnishing the information requested on this form is optional for the patient. Failure to provide the information requested will not result in any negative consequence for the patient. Information collected on this form is to be maintained in the patient's medical record, and is subject to the same medical and legal protection as other information maintained in the patient's medical record. State law and regulation including reporting requirements and protection of patient confidentiality applies to all information identified on this form. Within the constraints of these laws and regulations, certain information collected on this form may be transferred to state and local governmental and regulating agencies, contracted health plans, and health care providers.