

<h2 style="margin: 0;">“STAYING HEALTHY” ASSESSMENT</h2> <h3 style="margin: 0;">Children, 0–3 years of age</h3>		<h2 style="margin: 0;">Patient Stamp</h2>	
_____ Patient Number		_____ Plan Name/Number	
If patient stamp not used, write in Patient and Plan Name/Number			

Child’s name (first, last)	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Today’s date	For Clinical Use
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.

Sample Question and Answer: Does your child go to preschool?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	Annual Review Date/Initials
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				Interventions Code/Date/Initials
Does Your Home Have:				
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 and stair gates 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. The phone number for the poison control center posted by your telephone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
Do You:				
6. Always put your child to sleep on his/her back, if younger than 12 months of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
7. Ever put your child to sleep with a bottle of juice, milk, or soda?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
8. Make sure your child’s teeth are brushed every day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
9. Always stay with your child when she/he is in the bathtub?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
10. Always put your child in a car seat and seat belt in the back seat of a car?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
11. Always walk around your car to check for children before backing out?	<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
<u>Does Your Child:</u>			
12.	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	
13.	Breastfeed?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
14.	Drink formula, milk, or eat yogurt at least 2 times each day?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skip	
15.	Eat fruits and vegetables every day?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Skip	
16.	Eat foods that may cause choking such as nuts, popcorn, hotdogs, whole grapes, or hard candy?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
17.	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	
18.	Spend time in a home where a gun is kept?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
19.	Spend time in a home with anyone who smokes?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
20.	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	
21.	Has your child ever witnessed or been a victim of abuse or violence?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
22.	Do you have other questions or concerns about your child's health? (Please identify) _____ _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	

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.