Pediatric SHA Questions by Age Group

	Responses in the Left Column **Do Not Require Follow-Up**	Responses in the Middle Column **Require Follow-Up**	**Pediatric Age Groups** *Question Numbers on Each Age Specific Questionnaire*						
			Months		**Years**				
			0–6	**7–12**	**1–2**	**3–4**	**5–8**	**9–11**	**12–17**
Nutrition									
Do you breastfeed your baby?	Yes	No	1	1					
Do you breastfeed your child?	Yes	No			1				
Does your baby drink or eat 3 servings of calcium rich foods daily, such as formula, milk, cheese, yogurt, soy milk, or tofu?	Yes	No		2					
Does your child drink or eat 3 servings of calcium rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No			2	1	1	1	
Do you drink or eat 3 servings of calcium rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No							1
Does your child eat fruits and vegetables at least two times per day?	Yes	No			3	2	2	2	
Do you eat fruits and vegetables at least two times per day?	Yes	No							2
Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes			4	3	3	3	
Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes							3
Does your child drink more than one small cup (4 - 6 oz.) of juice per day?	No	Yes			5	4	4		
Does your child drink more than one cup (8 oz.) of juice per day?	No	Yes						4	
Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes			6	5	5	5	

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Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Yes							4
Physical Activity									
Does your child play actively most days of the week?	Yes	No			7	6			
Does your child exercise or play sports most days of the week?	Yes	No					6	6	
Do you exercise or play sports most days of the week?	Yes	No							5
Are you concerned about your baby's weight?	No	Yes	2	3					
Are you concerned about your child's weight?	No	Yes			8	7	7	7	
Are you concerned about your weight?	No	Yes							6
Does your baby watch any TV?	No	Yes	3	4					
Does your child watch TV or play video games?	No	Yes			9				
Does your child watch TV or play video games less than 2 hours per day?	Yes	No				8	8	8	
Do you watch TV or play video games less than 2 hours per day?	Yes	No							7
Safety									
Does your home have a working smoke detector?	Yes	No	4	5	10	9	9	9	8

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Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	5	6	11	10	10		
If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	6	7	12	11			
Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	7	8	13	12			
Does your home have the phone number of the poison control center (800-222-1222) posted by your phone?	Yes	No	8	9	14	13	11	10	9
Do you always put your baby to sleep on her/his back?	Yes	No	9	10					
Do you always stay with your baby when she/he is in the bathtub?	Yes	No	10	11					
Do you always stay with your child when she/he is in the bathtub?	Yes	No			15	14			
Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	11	12					
Do you always place your child in a rear facing car seat in the back seat?	Yes	No			16				
Do you always place your child in a forward facing car seat in the back seat?	Yes	No				15			
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					12		
Does your child always use a seat belt in the back seat (or use a booster seat if under 4’9”)?	Yes	No						11	

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Is the car seat you use the right one for the age and size of your baby?	Yes	No	12	13					
Is the car seat you use the right one for the age and size of your child?	Yes	No			17	16			
Do you always wear a seatbelt when riding in a car?	Yes	No							10
Do you always check for children before backing your car out?	Yes	No			18	17			
Does your baby spend time near a swimming pool, river, or lake?	No	Yes		14					
Does your child spend time near a swimming pool, river, or lake?	No	Yes			19	18	13	12	
Does your baby spend time in a home where a gun is kept?	No	Yes	13	15					
Does your child spend time in a home where a gun is kept?	No	Yes			20	19	14	13	
Do you spend time in a home where a gun is kept?	No	Yes							11
Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes					15	14	
Do you spend time with anyone who carries a gun, knife, or other weapon?	No	Yes							12
Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No			21	20	16	15	
Do you always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No							13

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			0–6	7–12	1–2	3–4	5–8	9–11	12–17
Has your child ever witnessed or been a victim of abuse or violence?	No	Yes				21	17	16	
Have you ever witnessed abuse or violence?	No	Yes							14
Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?	No	Yes							15
Has your child been hit or has your child hit someone in the past year?	No	Yes					8	17	
Has your child ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes					19	18	
Have you ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes							16
Dental									
Do you give your baby a bottle with anything in it except formula, milk, or water?	No	Yes	14	16					
Do you help your child brush and floss her/his teeth daily?	Yes	No			22	22			
Does your child brush and floss her/his teeth daily?	Yes	No					20	19	
Do you brush and floss your teeth daily?	Yes	No							17
Mental Health									
Does your child often seem sad or depressed?	No	Yes					21	20	
Do you often feel sad, down, or hopeless?	No	Yes							18

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Alcohol, Tobacco, Drug Use (Tobacco Exposure)									
Does your baby spend time with anyone who smokes?	No	Yes	15	17					
Does your child spend time with anyone who smokes?	No	Yes			23	23	22	21	
Do you spend time with anyone who smokes?	No	Yes							19
Has your child ever smoked cigarettes or chewed tobacco?	No	Yes						22	
Do you smoke cigarettes or chew tobacco?	No	Yes							20
Are you concerned your child may be using or sniffing substances, such as glue, to get high?	No	Yes						23	
Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, methamphetamine (meth), ecstasy, etc.?	No	Yes							21
Do you use medicines not prescribed for you?	No	Yes							22
Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?	No	Yes						24	
Do you drink alcohol once a week or more?	No	Yes							23
If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes							24
Does your child have friends or family members who have a problem with drugs or alcohol?	No	Yes						25	
Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes							25

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Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes							26
Sexual Issues									
Has your child started dating or "going out" with boyfriends or girlfriends?	No	Yes						26	
Do you think your child might be sexually active?	No	Yes						27	
Have you ever been forced or pressured to have sex?	No	Yes							27
Have you ever had sex (oral, vaginal, anal)? *If no, skip to question 35.*	No	Yes							28
Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes							29
Have you or your partner(s) had sex with other people in the past year?	No	Yes							30
Have you or your partner(s) had sex without using birth control in the past year?	No	Yes							31
The last time you had sex, did you use birth control?	Yes	No							32
Have you or your partner(s) had sex without a condom in the past year?	No	Yes							33
Did you or your partner use a condom the last time you had sex?	Yes	No							34
Do you have concerns about liking someone of the same sex?	No	Yes							35

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Last Question (Open Ended)									
Do you have any other questions or concerns about your baby's health, development, or behavior? If yes, please describe:	No	Yes	16	18					
Do you have any other questions or concerns about your child's health, development, or behavior? If yes, please describe:	No	Yes			24	24			
Do you have any other questions or concerns about your child's health or behavior? If yes, please describe:	No	Yes					23	28	
Do you have any other questions or concerns about your health? If yes, please describe:	No	Yes							36
			16	**18**	**24**	**24**	**23**	**28**	**36**