# Staying Healthy Assessment

## 3 – 4 Years

<table>
<thead>
<tr>
<th>Child’s Name (first &amp; last)</th>
<th>Date of Birth</th>
<th>Female</th>
<th>Male</th>
<th>Today’s Date</th>
<th>In Child/Day Care?</th>
<th>Need Help with Form?</th>
<th>Person Completing Form</th>
<th>Need Interpreter?</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
<td>□ Parent □ Relative □ Friend □ Guardian □ Other (Specify)</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

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.

### Nutrition

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

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. cup) 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

### Physical Activity

6. Does your child play actively most days of the week?  
   - Yes  
   - No  
   - Skip

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

### Safety

9. Does your home have a working smoke detector?  
   - Yes  
   - No  
   - Skip

10. Have you turned your water temperature down to low-warm (less than 120 degrees)?  
    - Yes  
    - No  
    - Skip

11. If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?  
    - Yes  
    - No  
    - Skip

12. Does your home have cleaning supplies, medicines, and matches locked away?  
    - Yes  
    - No  
    - Skip

13. Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?  
    - Yes  
    - No  
    - Skip

14. Do you always stay with your child when she/he is in the bathtub?  
    - Yes  
    - No  
    - Skip
<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Skip</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Do you always place your child in a forward facing car seat in the back seat?</td>
<td></td>
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<tr>
<td>16</td>
<td>Is the car seat you use the right one for the age and size of your child?</td>
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<tr>
<td>17</td>
<td>Do you always check for children before backing your car out?</td>
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<tr>
<td>18</td>
<td>Does your child spend time near a swimming pool, river, or lake?</td>
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<tr>
<td>19</td>
<td>Does your child spend time in a home where a gun is kept?</td>
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<td>20</td>
<td>Does your child always wear a helmet when riding a bike, skateboard, or scooter?</td>
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<td>21</td>
<td>Has your child ever witnessed or been a victim of abuse or violence?</td>
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<td>22</td>
<td>Do you help your child brush and floss her/his teeth daily?</td>
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<td>23</td>
<td>Does your child spend time with anyone who smokes?</td>
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<td>24</td>
<td>Do you have any other questions or concerns about your child’s development, health or behavior?</td>
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</tbody>
</table>

*If yes, please describe:*

<table>
<thead>
<tr>
<th>Clinic Use Only</th>
<th>Worksheet Use Only</th>
<th>Comments:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Nutrition</td>
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<td></td>
<td>Physical Activity</td>
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<td>Safety</td>
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<td>Dental Health</td>
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<td>Tobacco Exposure</td>
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</tbody>
</table>

**Patient Declined the SHA**

**PCP's Signature**

**Print Name:**

**Date:**