Staying Healthy Assessment

3 – 4 Years

Child's Name (first & last)		Date of Birth Male		Today's Date		e In	In Child/Day Care?	
				iond 🗆 Cuardian			Need Help with Form?	
Person Completing Form			iend 🗌 Guardian 🛛 N			Yes No		
Please answer all the questions on this form as best you can. Circle "Skip an answer or do not wish to answer. Be sure to talk to the doctor if you anything on this form. Your answers will be protected as part of your ma					estions d		Need Interpreter?	
1	Does your child drink or eat 3 set daily, such as milk, cheese, yogu	Yes	No	Skip	Nutrition			
2	Does your child eat fruits and veg per day?	vo times	Yes	No	Skip			
3	Does your child eat high fat food ice cream, or pizza more than one	ods, chips,	No	Yes	Skip			
4	Does your child drink more than of juice per day?	- 6 oz. cup)	No	Yes	Skip			
5	Does your child drink soda, juice drinks, or other sweetened drinks		No	Yes	Skip			
6	Does your child play actively mo	k?	Yes	No	Skip	Physical Activity		
7	Are you concerned about your child's weight?				Yes	Skip		
8	Does your child watch TV or pla hours per day?	s than 2	Yes	No	Skip			
9	Does your home have a working smoke detector?				No	Skip	Safety	
10	Have you turned your water temperature down to low-warm (less than 120 degrees)?				No	Skip		
11	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?				No	Skip		
12	Does your home have cleaning su matches locked away?	upplies, medicines	, and	Yes	No	Skip		
13	Does your home have the phone Control Center (800-222-1222) p			Yes	No	Skip		
14	Do you always stay with your ch bathtub?	Yes	No	Skip				

15	Do you always place your child in a forward facing car seat in the back seat?	Yes	No	Skip	
16	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
17	Do you always check for children before backing your car out?	Yes	No	Skip	
18	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
19	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
20	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
21	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
24	Do you have any other questions or concerns about your child's development, health or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:				
□ Nutrition									
Physical Activity									
Safety									
🗌 Dental Health					[
🗌 Tobacco Exposure					Patient Declined the SHA				
PCP's Signature		Pı	rint Name:		Date:				
SHA ANNUAL REVIEW									
PCP's Signature	Print Name:			Date:					
PCP's Signature		Pı	rint Name:		Date:				