

# Staying Healthy Assessment

## 7 - 12 Months

|                             |   |  |              |  |
|-----------------------------|---|--|--------------|--|
| Child's Name (first & last) | Date of Birth   | <input type="checkbox"/> Female<br><input type="checkbox"/> Male | Today's Date | In Child/Day Care?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |
| Person Completing Form      | <input type="checkbox"/> Parent <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Guardian<br><input type="checkbox"/> Other (Specify) |  |              | Need Help with Form?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |

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.

Need Interpreter?  
 Yes  No

**Clinic Use Only:**

|                   |  |     |     |      |
|-------------------|--|-----|-----|------|
| Nutrition         |  |     |     |      |
| 1                 | Do you breastfeed your baby?   | Yes | No  | Skip |
| 2                 | Does your baby drink or eat 3 servings of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or tofu? | Yes | No  | Skip |
| Physical Activity |  |     |     |      |
| 3                 | Are you concerned about your baby's weight?  | No  | Yes | Skip |
| 4                 | Does your baby watch any TV?   | No  | Yes | Skip |
| Safety            |  |     |     |      |
| 5                 | Does your home have a working smoke detector?  | Yes | No  | Skip |
| 6                 | Have you turned your water temperature down to low-warm (less than 120 degrees)?   | Yes | No  | Skip |
| 7                 | If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?                             | Yes | No  | Skip |
| 8                 | Does your home have cleaning supplies, medicines, and matches locked away?   | Yes | No  | Skip |
| 9                 | Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?                               | Yes | No  | Skip |
| 10                | Do you always put your baby to sleep on her/his back?  | Yes | No  | Skip |

|    |  |     |     |      |                  |
|----|--|-----|-----|------|------------------|
| 11 | Do you always stay with your baby when she/he is in the bathtub?                               | Yes | No  | Skip |                  |
| 12 | Do you always place your baby in a rear facing car seat in the back seat?                      | Yes | No  | Skip |                  |
| 13 | Is the car seat you use the right one for the age and size of your baby?                       | Yes | No  | Skip |                  |
| 14 | Does your baby spend time near a swimming pool, river, or lake?                                | No  | Yes | Skip |                  |
| 15 | Does your baby spend time in a home where a gun is kept?                                       | No  | Yes | Skip |                  |
| 16 | Do you give your baby a bottle with anything except formula, breast milk, or water?            | No  | Yes | Skip | Dental Health    |
| 17 | Does your baby spend time with anyone who smokes?  | No  | Yes | Skip | Tobacco Exposure |
| 18 | Do you have any other questions or concerns about your baby's health, development or behavior? | No  | Yes | Skip | Other Questions  |

*If yes, please describe:*

| <b><i>Clinic Use Only</i></b>              | Counseled                | Referred                 | Anticipatory Guidance    | Follow-up Ordered        | Comments:  |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> Nutrition         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |
| <input type="checkbox"/> Physical Activity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |
| <input type="checkbox"/> Safety            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |
| <input type="checkbox"/> Dental Health     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |
| <input type="checkbox"/> Tobacco Exposure  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |  |
|  |                          |                          |                          |                          | <input type="checkbox"/> <b>Patient Declined the SHA</b> |
| PCP's Signature:                           |                          | Print Name:              |                          |                          | Date:  |