Staying Healthy Assessment

1 -2 Years

Child's Name (first & last) Dat		Date of Birth	Female Today's Da		lay's Dat	e I	e In Child/Day Care?	
			☐ Male				☐ Yes ☐ No	
Person Completing Form Parent Relative Fr				riend 🔲 Guardian			Need Help with Form?	
Other (Specify)							☐ Yes ☐ No	
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		
1					No	Skip	Clinic Use Only: Nutrition	
2	Does your child drink or eat 3 servings of calcium-rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?				No	Skip		
3	Does your child eat fruits and vegetables at least two times per day?				No	Skip		
4	Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?				Yes	Skip		
5	Does your child drink more than one small cup $(4 - 6 \text{ oz.})$ of juice per day?				Yes	Skip		
6	Does your child drink soda, juice drinks, or other sweetened drinks		No	Yes	Skip			
7	Does your child play actively most days of the week?				No	Skip	Physical Activity	
8	Are you concerned about your child's weight?				Yes	Skip		
9	Does your child watch TV or play video games?				Yes	Skip		
10	Does your home have a working s	smoke detector?		Yes	No	Skip	Safety	
11	Have you turned your water temp (less than 120 degrees)?	ow-warm	Yes	No	Skip			
12	If your home has more than one f guards on the windows and gates	•	safety	Yes	No	Skip		
13	Does your home have cleaning su matches locked away?	ipplies, medicines	, and	Yes	No	Skip		
14	Does your home have the phone r Control Center (800-222-1222) pe		:	Yes	No	Skip		

15	Do you always stay with your child when she/he is in the bathtub?	Yes	No	Skip	
16	Do you always place your child in a rear facing car seat in the back seat?	Yes	No	Skip	
17	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
18	Do you always check for children before backing your car out?	Yes	No	Skip	
19	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
20	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
21	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	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 health, development 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		Pr	int Name:		Date:			
SHA ANNUAL REVIEW								
PCP's Signature		Pr	int Name:		Date:			