7-8 years

Please complete these forms before your visit today.

Thank you!

Staying Healthy Assessment

5-8 Years

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐Guardian ☐ Other (specify)			Need Help with Form ☐ Yes ☐ 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:
1	Does your child drink or eat 3 servings of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or tofu?	Yes	No	Skip	*Nutrition*
2	Does your child eat fruits and vegetables at least 2 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.) 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	
6	Does your child exercise or play sports most days of the week?	Yes	No	Skip	*Physical Activity*
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 a day?	Yes	No	Skip	
9	Does your home have a working smoke detector?	Yes	No	Skip	*Safety*
10	Have you turned you water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
11	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
12	Do you always place your child in a booster seat in the back seat (or use a seatbelt if your child is over 4'9")?	Yes	No	Skip	
13	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
14	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
15	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip	
16	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
17	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
18	Has your child been hit or hit someone in the past year?	No	Yes	Skip	
19	Has your child ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
20	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	*Dental Health*
21	Does your child often seem sad or depressed?	No	Yes	Skip	*Mental Health*
22	Does your child spend time with anyone who smokes?	No	Yes	Skip	*Drug, Alcohol & Tobacco Exposure*

23	Does your child have any family members who have or have had a problem with alcohol or other drugs?	No	Yes	Skip	
24	Does your child have any family members who suffer from depression, anxiety, PTSD or other mental health conditions?	No	Yes	Skip	*Home Environment*
25	(For parents) Does a partner, or anyone at home, hurt, hit or threaten you?	No	Yes	Skip	
26	Has your child ever been away from either parent due to parental illness, separation, foster care, parental incarceration or other reasons?	No	Yes	Skip	
27	Has anything really scary or upsetting happened to your child or anyone in your family?	No	Yes	Skip	
28	In the last year, have you been worried that your food would run out before you were able to get more?	No	Yes	Skip	*Other Questions*
29	In the last year, have you been worried that you would need to move out of a place you were staying due to inability to afford the rent, or for other reasons?	No	Yes	Skip	
30	Do you have any other questions or concerns about your baby's health, development, or behavior?	No	Yes	Skip	

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Mental Health	☐	☐	☐	☐	
☐ Drug, Alcohol & Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**
☐ Home Environment	☐	☐	☐	☐	
PCP's Signature:	Print Name:				Date:
SHA ANNUAL REVIEW					
PCP's Signature:	Print Name:				Date:
PCP's Signature:	Print Name:				Date:
PCP's Signature:	Print Name:				Date:

GARDNER
Packard Children's Health Center

Family Needs Screening[1,2]

Our goal at Gardner Packard Children's Health Center is to provide the best possible care for your child and family. We would like to make sure you know resources available to you for your family's needs. Please answer both questions and give to your child's doctor at the beginning of the visit. Thank You!

1. Which of these would you like help with today? (Check all that apply)

   - ❑ Food
   - ❑ Housing
   - ❑ Living conditions (like mold in your home)
   - ❑ Utilities
   - ❑ Transportation
   - ❑ Tutoring or Homework Help
   - ❑ Childcare or preschool

   - ❑ None of these

2. Which of the concerns above is most important to talk about today?

Adapted from: [1] Centers for Medicare & Medicaid Services (CMS) Accountable Health Communities (AHC) Health Related Social Needs Screening Tool and [2] WE-CARE: Well-child care visit; Evaluation; Community resources; Advocacy; Referral; Education. Modified on 6/12/2018.

GARDNER
Packard Children's Health Center

Medical Record Number

Patient Name

Addressograph or Label

TUBERCULOSIS RISK FACTOR ASSESSMENT

Exposure Risk

1. Has a family member or someone your child has been in contact with had tuberculosis disease? ❑ Yes ❑ No
2. Has your child, a family member, or someone your child has been in contact with had a positive TB test or received medications for TB? ❑ Yes ❑ No
3. Was your child born in another country*? ❑ Yes ❑ No
4. Has your child traveled outside of the United States for more than a month? ❑ Yes ❑ No

*Excluding Canada, Australia, New Zealand, or Western and Northern European countries

I attest that the above information is true to the best of my knowledge.

Parent/Guardian Signature: _____Date: _____