Staying Healthy Assessment

0 – 6 Months

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	Do you breastfeed your baby?	Yes ○	No ○	Skip ○	Nutrition
2	Are you concerned about your baby's weight?	No ○	Yes ○	Skip ○	Physical Activity
3	Does your baby watch any TV?	No ○	Yes ○	Skip ○	
4	Does your home have a working smoke detector?	Yes ○	No ○	Skip ○	Safety
5	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes ○	No ○	Skip ○	
6	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes ○	No ○	Skip ○	
7	Does your home have cleaning supplies, medicines, and matches locked away?	Yes ○	No ○	Skip ○	
8	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes ○	No ○	Skip ○	
9	Do you always put your baby to sleep on her/his back?	Yes ○	No ○	Skip ○	
10	Do you always stay with your baby when she/he is in the bathtub?	Yes ○	No ○	Skip ○	

11	Do you always place your baby in a rear facing car seat in the back seat?	Yes ○	No ○	Skip ○	
12	Is the car seat you use the right one for the age and size of your baby?	Yes ○	No ○	Skip ○	
13	Does your baby spend time in a home where a gun is kept?	No ○	Yes ○	Skip ○	
14	Do you give your baby a bottle with anything except formula, breast milk, or water?	No ○	Yes ○	Skip ○	Dental Health
15	Does your baby spend time with anyone who smokes?	No ○	Yes ○	Skip ○	Tobacco Exposure
16	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:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered
☐ Nutrition	☐	☐	☐	☐
☐ Physical Activity	☐	☐	☐	☐
☐ Safety	☐	☐	☐	☐
☐ Dental Health	☐	☐	☐	☐
☐ Tobacco Exposure	☐	☐	☐	☐

Comments:

☐ **Patient Declined the SHA**

PCP's Signature: Print Name: Date: