Staying Healthy Assessment

0 - 6 Months

Child's Name (first & last)		Date of Birth	of Birth Female		Today's Date		In Child/Day Care?	
Person Completing Form Parent Other (Spec			Relative				Need Help with Form? 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 mo					estions (Need Interpreter? Yes No Clinic Use Only:	
1	Do you breastfeed your baby?		Yes	No	Skip	Nutrition		
2	Are you concerned about your bal		No	Yes	Skip	Physical Activity		
3	Does your baby watch any TV?		No	Yes	Skip)		
4	Does your home have a working smoke detector?				No	Skip	Safety	
5	Have you turned your water temperature down to low-warm (less than 120 degrees)?				No	Skip)	
6	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?				No	Skip)	
7	Does your home have cleaning supplies, medicines, and matches locked away?				No	Skip)	
8	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?				No	Skip)	
9	Do you always put your baby to sl	eep on her/his bad	ck?	Yes	No	Skip)	
10	Do you always stay with your bab bathtub?	n the	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?		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	Comments:
Nutrition					
Physical Activity					
Safety					
☐ Dental Health					
☐ Tobacco Exposure					☐ Patient Declined the SHA
PCP's Signature:		Print Nam	e:		Date:
					: