

Staying Healthy Assessment 0 – 6 Months

Child's Name (first & last)	Date of Birth	<input type="checkbox"/> Female <input type="checkbox"/> Male	Today's Date	In Child/Day Care? <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 <input type="checkbox"/> Other (Specify)			Need Help with Form? <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:

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

11	Do you always place your baby in a rear facing car seat in the back seat?	Yes <input type="radio"/>	No <input type="radio"/>	Skip <input type="radio"/>	
12	Is the car seat you use the right one for the age and size of your baby?	Yes <input type="radio"/>	No <input type="radio"/>	Skip <input type="radio"/>	
13	Does your baby spend time in a home where a gun is kept?	No <input type="radio"/>	Yes <input type="radio"/>	Skip <input type="radio"/>	
14	Do you give your baby a bottle with anything except formula, breast milk, or water?	No <input type="radio"/>	Yes <input type="radio"/>	Skip <input type="radio"/>	Dental Health
15	Does your baby spend time with anyone who smokes?	No <input type="radio"/>	Yes <input type="radio"/>	Skip <input type="radio"/>	Tobacco Exposure
16	Do you have any other questions or concerns about your baby's health, development, or behavior?	No <input type="radio"/>	Yes <input type="radio"/>	Skip <input type="radio"/>	Other Questions

If yes, please describe:

<i>Clinic Use Only</i>	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"/> Patient Declined the SHA
PCP's Signature:		Print Name:			Date: