

“STAYING HEALTHY” ASSESSMENT Pre-adolescents, 9–11 years of age

Patient Stamp	
_____ Patient Number	_____ Plan Name/Number
<i>If patient stamp not used, write in Patient and Plan Name/Number</i>	

Child’s name (first, last)	Date of birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Today’s date	For Clinical Use
Your name	Relationship to child <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Relative <input type="checkbox"/> Friend <input type="checkbox"/> Other			Assistance needed: Reading: <input type="checkbox"/> Yes <input type="checkbox"/> No Interpreter: <input type="checkbox"/> Yes <input type="checkbox"/> No

You and your child’s health care team can work together towards better health. Please answer these questions as best you can. You may check (✓) “Skip” if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your child’s medical record.

Sample Question and Answer: Does your child go to school? Yes No Skip

				Interventions Code/Date/Initials
Does Your Child:				
1. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
2. See the dentist at least once a year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
3. Drink milk or eat yogurt or cheese at least 3 times each day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
4. Eat fruits and vegetables every day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
5. Eat only a limited amount of fried or fast foods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
6. Play actively 5 days a week?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
7. Need to lose or gain weight?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
8. Often feel sad or depressed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	
9. Always wear a helmet when riding a bike or skateboard?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
10. Always wear a seatbelt when riding in a car?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip	
11. Spend time in a home where a gun is kept?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip	

For Clinical Use

Intervention Codes: C: Counseling EM: Educational Materials R: Referral F: Follow-up Needed SPN: See Progress Notes

			<i>For Clinical Use</i>
			Interventions Code/Date/Initials
<u>Does Your Child:</u>			
12.	Spend time with any friends who carry a gun, knife, club, or other weapon?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
13.	Spend time in a home with anyone who smokes?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
14.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
<u>Has Your Child:</u>			
15.	Ever smoked cigarettes or chewed tobacco?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
16.	Ever had alcohol such as beer, wine, wine coolers, or liquor?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
17.	Ever smoked marijuana, sniffed glue, or used street drugs?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
18.	Had friends or family members who had a problem with drugs or alcohol?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
19.	Started dating or "going with" boyfriends/girlfriends?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
20.	Become sexually active?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
21.	Ever been molested or sexually abused?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
22.	Ever witnessed or been a victim of physical abuse or violence?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
23.	Had problems at home or school?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	
24.	Do you have other questions or concerns about your child's health? (Please identify) _____ _____ _____	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Skip	

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Privacy Statement

The Information Practices Act of 1977 (California Civil Code 1798) and the Federal Privacy Act (5 USC 552a, Subdivision (E)(3)) require this notice to be provided when collecting personal information from individuals. The information on this form is requested by your health care provider, health plan, and the Department of Health Services for purposes of providing health education services. Furnishing the information requested on this form is optional for the patient. Failure to provide the information requested will not result in any negative consequence for the patient. Information collected on this form is to be maintained in the patient's medical record, and is subject to the same medical and legal protection as other information maintained in the patient's medical record. State law and regulation including reporting requirements and protection of patient confidentiality applies to all information identified on this form. Within the constraints of these laws and regulations, certain information collected on this form may be transferred to state and local governmental and regulating agencies, contracted health plans, and health care providers.