

Staying Healthy Assessment (5-8 Years)

Question #	Question Text	Yes	No	Skip
1	Does your child drink or eat 3 servings of calcium rich foods daily such as formula, breastmilk, cheese, yogurt, soy milk or tofu?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Does your child eat fruits and vegetables at least two times per day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	Does your child eat high fat foods, such as fried foods, chips, ice cream or pizza more than once a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Does your child drink more than one small cup (4-6oz) of juice per day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Does your child drink soda, juice drinks, sports drinks, energy drink or other sweetened drinks more than once per week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Does your child play actively most days of the week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Are you concerned about your child's weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Does your child watch any tv or play video games less than 2 hours per day?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Does your home have a working smoke detector?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Have you turned your water temperature down to low-warm (less than 120 degrees?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Does your home have the phone number of Poison Control Center (800-222-1222) posted by your phone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Do you always place your child in a booster seat in the back seat (or use a seat belt if your child is over 4'9"?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Does your child spend time near a swimming pool, river or lake?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14	Does your child spend time in a home where a gun is kept?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Does your child spend time with anyone who carries a gun, knife or other weapon?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	Does your child always wear a helmet when riding a bike, skateboard or scooter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Has your child ever witnessed or been a victim of abuse or violence??	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Has your child been hit or hit someone in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	Has your child been bullied or felt unsafe at school or in your neighborhood?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	Do you help your child brush and floss her/his teeth daily?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	Does your child often seem sad or depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22	Does your child spend time with anyone who smokes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23	Do you have any other questions or concerns about your child's health, development or behavior?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please describe: _____

Is an interpreter needed today? Yes / No

Is the child in daycare? Yes / No