

Staying Healthy Assessment (7-12 months)

Question #	Question Text	Yes	No	Skip
1	Do you breastfeed your baby?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	Does your baby 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"/>
3	Are you concerned about your baby's weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Does your baby watch any tv?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Does your home have a working smoke detector?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Have you turned your water temperature down to low-warm (less than 120 degrees?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Does your home have more than one floor, do you have safe guards on the windows and gates for the stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Does your home have cleaning supplies, medicines and matches locked away?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	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"/>
10	Do you always put your baby to sleep on her/his back?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Do you always stay with your baby when she/he is in the bathtub?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Do you always place your baby in a rear facing car seat in the back seat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Is the car seat you use the right one for the age and size of your baby?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Does your baby spend time near a swimming pool, river or lake?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	Does your baby spend time in a home where a gun is kept?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16	Do you give your baby a bottle with anything except formula, breast milk or water?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	Does your baby spend time with anyone who smokes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	Do you have any other questions or concerns about your baby'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