

Whole Child Assessment- Version 2 for 6 – 8 Years

Please answer all the questions on this form as best you can. It will help us know how we can help your child be healthy. **You may skip any question if you do not know an answer or do not want to answer.** You may add comments to explain your answers. We will keep this information confidential, unless there is concern that your child is being hurt.

1	Person completing form	<input type="checkbox"/> Biological Parent(s) <input type="checkbox"/> Step Parent(s) <input type="checkbox"/> Adopted Parent(s) <input type="checkbox"/> Foster Parent(s) <input type="checkbox"/> Friend(s) <input type="checkbox"/> Other (<i>specify</i>)									
2	What grade is your child in school?	K	1	2	3	4	5	6	7	1 Interval History	
	Is your child in special ed OR are grades below average?	No			Unsure			Yes			
3	Since the last visit, has your child										
	• Been seen in another clinic?	No	Unsure			Yes					
	• Developed a new illness?	No	Unsure			Yes					
	• Been seen in the Emergency Room?	No	Unsure			Yes					
	• Been hospitalized?	No	Unsure			Yes					
	• Had an operation?	No	Unsure			Yes					
4	Since the last visit, have there been any changes or events that were stressful, scary, or upsetting to your child?	No		Unsure			Yes				
5	Do you have any questions or concerns about your child's health or behavior at home or school? <i>If yes, please describe:</i>	No		Unsure			Yes				
6	Has a family member or close contact had tuberculosis disease during your child's lifetime?	No		Unsure			Yes			10 Tuberculosis	
7	Was your child born in the United States?	Yes		Unsure			No				
8	Has your child lived or traveled outside of the United States for at least a month ?	No		Unsure			Yes				
9	Does your child brush and floss her/his teeth twice daily?	Often		Sometimes			Never			9 Dental	
10	In the past year, has your child been seen twice by a dentist?	Yes		Unsure			No				
11	How many servings of fruit (about the size of your child's fist) does your child eat each day ?	3+		2			0-1			8 Nutrition	
12	How many servings of vegetables (about the size of your child's fist) does your child eat each day ?	4+		2-3			0-1				
13	How many servings a day does your child drink or eat of calcium-rich foods, such as milk, cheese, yogurt, soy milk, OR tofu?	3+		2			0-1				
14	How many times a day does your child drink a cup (about 8 oz) of juice, soda, sports drinks, energy drinks, OR other sweetened drinks?	0-1		2			3+				
15	How many times a week does your child eat breakfast?	6-7		3-5			0-2				
16	How many times a week does your child eat high-fat foods, such as fried foods, pizza, OR other fast food?	0-1		2-3			4+				
17	How many times a week does your child snack on chips, pretzels, OR crackers?	0-1		2-3			4+				
18	How many times a week does your child eat ice cream, cookies, OR other desserts?	0-1		2-3			4+				

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19	How many times a week does your child play actively, such as running or jumping enough to cause faster breathing?	6-7	3-5	0-2	7 Physical Activity	
20	On those days that your child plays actively, how many minutes does she/he play?	60+	30-59	0-29		
21	Outside of schoolwork, how many hours a day does your child spend on screen time (TV, phone, computer, tablet, video games, etc.)?	0-1	2+ Sometimes	2+ Often		
22	Is your child involved in sports, dance, music, religious activities, or other extracurriculars?	Yes	Unsure	No		
23	Does your child have trouble falling asleep or staying asleep?	Never	Sometimes	Often	6 Sleep	
24	Do you feel your child is difficult to take care of?	Never	Sometimes	Often		
25	Do you find you need to shout or yell at your child?	Never	Sometimes	Often	5 Relationships	
26	Do you find you need to hit or spank your child?	Never	Sometimes	Often		
27	Are your child’s parents separated, divorced, or not living together?	No	Deceased parent	Unsure		Yes
28	Does your family look out for each other, feel close to each other, and support each other?	Often	Sometimes	Never		
29	Did a parent or household member get arrested, deported, go to prison, jail, or another correctional facility during your child’s lifetime?	No	Unsure	Yes		
30	Do you know or are you concerned that anyone touched your child, or forced your child to touch that person, in a sexual way?	No	Unsure	Yes		
31	Does your child seem nervous or afraid?	Never	Sometimes	Often		4 Mental Health
32	Does your child seem sad or unhappy?	Never	Sometimes	Often		
33	Does your child have trouble with anger or get into fights with other children?	Never	Sometimes	Often		
34	Does your child have trouble paying attention or sitting still?	Never	Sometimes	Often		
35	Was a parent or household member ever depressed, mentally ill, OR suicidal?	No	Unsure	Yes		
36	How about you— Over the past 2 weeks , how often have you been bothered by any of the following problems? A1. Little interest or pleasure in doing things A2. Feeling down, depressed, or hopeless B1. Feeling nervous, anxious, or on edge B2. Not being able to stop or control worrying	Not at all	Several days	More than half the days	Nearly every day	
37	Does your child spend time with anyone who smokes, vapes, uses e-cigarettes, OR chews tobacco?	No	Unsure	Yes	3 Substances	
38	In the past year, how many times have you had 4 or more drinks containing alcohol in one day ?	0	1	2+		
39	Did a parent or household member ever have a problem with drugs OR alcohol?	No	Unsure	Yes		
40	Does your home have a working smoke detector and carbon monoxide detector?	Yes	Unsure	No	2 Safety	
41	Does your child always use a seat belt in the back seat (or use a booster seat if under 4’9”)?	Yes	Unsure	No		

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42	Does your child always wear a helmet when on a bike, skateboard, scooter, or roller blades?	Yes	Does not ride	No	2 Safety	
43	Does your child spend time near a swimming pool, river, lake, or hot tub?	No	Unsure	Yes		
44	Does your child spend time with anyone who carries a weapon, or spend time in a home where a gun is kept?	No	Unsure	Yes		
45	Has your child (as a baby or when older) ever seen or heard adults in the home pushing, hitting, kicking, OR physically threatening each other?	No	Unsure	Yes		
46	Has your child ever lived with a parent or other adult who physically hurt the child in anger?	No	Unsure	Yes		
47	Has your child ever been bullied or cyber bullied, or felt unsafe at school or in your neighborhood?	No	Unsure	Yes		
48	On average, how difficult was it for your family to meet expenses for basic needs like food, clothing, and housing in the last year ?	Not at all	A little	Somewhat		Fairly

If you have additional concerns, comments, or questions, please describe here:

<i>Clinic Use Only:</i> circle each question with a positive response, sum number of circled questions											
Child-ACE Exposures:	25	27	28	29	30	35	39	45	46	48	$\sum =$
Child-ACE Risks:	1	24	26	36A	36B	38					$\sum =$
											Child-ACE Total $\sum =$
PCP's Signature					Print Name					Date	