Whole Child Assessment- Version 3 for 2 – 3 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	□ Biological Parent(s) □ Step Parent(s) □ Adopted Parent(s) □ Foster Parent(s) □ Friend(s) □ Other *(specify)*			
2	Does your child go to daycare or preschool?	Yes	Unsure	No	1 Interval History
3	Since the last visit, has your child • Been seen in another clinic? • Developed a new illness? • Been seen in the Emergency Room? • Been hospitalized? • Had an operation?	 No No No No No	 Unsure Unsure Unsure Unsure Unsure	 Yes Yes Yes Yes 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 growth, development, or behavior? *If yes, please describe:*	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	Do you help your child brush 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 **OR** vegetables (about the size of your child's fist) does your child eat each **day**?	5+	2-4	0-1	8 Nutrition
12	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	
13	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+	
14	How many times a **week** does your child eat breakfast?	6-7	3-5	0-2	
15	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+	
16	Is your child enrolled in WIC?	Yes	Unsure	No	

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17	Does your child play actively for at least 1 hour each day?	Yes	Unsure		No	7 Physical Activity
18	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	
19	Does your child have trouble falling asleep or staying asleep?	Never	Sometimes		Often	6 Sleep
20	Do you feel your child is difficult to take care of?	Never	Sometimes		Often	5 Relationships
21	Do you find you need to shout or yell at your child?	Never	Sometimes		Often	
22	Do you find you need to hit or spank your child?	Never	Sometimes		Often	
23	Are your child's parents separated, divorced, or not living together?	No	Deceased parent	Unsure	Yes	
24	Does your family look out for each other, feel close to each another, and support each other?	Often	Sometimes		Never	
25	Did a parent or household member get arrested, deported, go to prison, jail, or other correctional facility during your child's lifetime?	No	Unsure		Yes	
26	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	
27	Is your child fussy or irritable?	Never	Sometimes		Often	4 Mental Health
28	Was a parent or household member **ever** depressed, mentally ill, **OR** suicidal?	No	Unsure		Yes	
29	How about you— Over the past **2 weeks**, how often have **you** been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day	
	A1. Little interest or pleasure in doing things	0	1	2	3	
	A2. Feeling down, depressed, or hopeless	0	1	2	3	A:
	B1. Feeling nervous, anxious, or on edge	0	1	2	3	
	B2. Not being able to stop or control worrying	0	1	2	3	B:
30	Does your child spend time with anyone who smokes, vapes, **OR** uses e-cigarettes?	No	Unsure		Yes	3 Substances
31	In the past year, how many times have **you** had 4 or more drinks containing alcohol **in one day**?	0	1		2+	
32	Did a parent or household member **ever** have a problem with drugs **OR** alcohol?	No	Unsure		Yes	
33	Does your home have a working smoke detector and carbon monoxide detector?	Yes	Unsure		No	2 Safety
34	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	Unsure		No	
35	Do you **always** stay with your child when she/he is in the bathtub?	Yes	Unsure		No	
36	Do you **always** place your child in a forward-facing car seat in the back seat?	Yes	Unsure		No	
37	Does your child **always** wear a helmet when on a bike, skateboard, scooter, or roller blades?	Yes	Does not ride		No	
38	Does your child spend time near a swimming pool, river, lake, or hot tub?	No	Unsure		Yes	
39	Does your child spend time in a home where a gun is kept?	No	Unsure		Yes	

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40	Has your child **ever** seen or heard adults in the home pushing, hitting, kicking, **OR** physically threatening each other?	No	Unsure	Yes	2 Safety
41	Has your child **ever** lived with a parent or other adult who physically hurt the child in anger?	No	Unsure	Yes	
42	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 Very	
43	Would you like someone to follow-up with you about community resources?	No	Unsure	Yes	

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

Clinic Use Only: *circle each question with a positive response, sum number of circled questions*		
Child-ACE Exposures: 21 23 24 25 26 28 32 40 41 42 ∑ =		
Child-ACE Risks: 1 20 22 29A 29B 31 ∑ =		
Child-ACE Total ∑ =		
PCP's Signature	Print Name	Date