Whole Child Assessment- Version 3 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	□ Biological Parent(s) □ Step Parent(s) □ Adopted Parent(s) □ Foster Parent(s) □ Friend(s) □ Other *(specify)*	
2a.	What grade is your child in school?	K 1 2 3 4 5 6 7	1 Interval History
2b.	Are your child's grades below average?	No / Unsure / Yes	
2c.	Does your child participate in special ed or have a school IEP/504 plan?	No / Unsure / Yes	
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 / Unsure / Yes No / Unsure / Yes No / Unsure / Yes No / Unsure / Yes 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 growth 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	Does your child brush her/his teeth twice daily with fluoride toothpaste?	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	5 Relationships
25	Do you find you need to shout or yell at your child?	Never	Sometimes	Often	
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?	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	A:
	A2. Feeling down, depressed, or hopeless	0	1 / 2	3	
	B1. Feeling nervous, anxious, or on edge	0	1 / 2	3	B:
	B2. Not being able to stop or control worrying	0	1 / 2	3	
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	Very
49	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: 25 27 28 29 30 35 39 45 46 48			∑ =
Child-ACE Risks: 1 24 26 36A 36B 38			∑ =
		Child-ACE Total	∑ =
PCP's Signature	Print Name		Date