

Whole Child Assessment- Version 3 for 12 – 23 Months

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	Does your child go to daycare?	No	Unsure	Yes	1 Interval History
3	Since the last visit, has your child	No	Unsure	Yes	
	• 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 growth, development, or behavior? <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	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 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+	
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	Does your child watch anything on a TV, phone, computer, or tablet?	Never	Sometimes		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	4 Mental Health
26	Is your child fussy or irritable?	Never	Sometimes		Often	
27	Was a parent or household member ever depressed, mentally ill, OR suicidal?	No	Unsure		Yes	
28	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	
29	Does your child spend time with anyone who smokes, vapes, OR uses e-cigarettes?	No	Unsure		Yes	3 Substances
30	In the past year, how many times have you had 4 or more drinks containing alcohol in one day ?	0	1		2+	
31	Did a parent or household member ever have a problem with drugs OR alcohol?	No	Unsure		Yes	
32	Does your home have a working smoke detector and carbon monoxide detector?	Yes	Unsure		No	2 Safety
33	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	Unsure		No	
34	Does your child live in, or spend a lot of time in, a place built before 1978 that has peeling or chipped paint or that has been recently remodeled?	No	Unsure		Yes	
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 rear-facing car seat in the back seat?	Yes	Unsure		No	
37	Does your child spend time near a swimming pool, river, lake, or hot tub?	No	Unsure		Yes	
38	Does your child spend time in a home where a gun is kept?	No	Unsure		Yes	

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39	Has your child ever seen or heard adults in the home pushing, hitting, kicking, OR physically threatening each other?	No	Unsure	Yes	2 Safety		
40	Has your child ever lived with a parent or other adult who physically hurt the child in anger?	No	Unsure	Yes			
41	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
42	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:

<i>Clinic Use Only:</i> circle each question with a positive response, sum number of circled questions										
Child-ACE Exposures:	21	23	24	25	27	31	39	40	41	$\Sigma =$
Child-ACE Risks:	1	20	22	28A	28B	30				$\Sigma =$
Child-ACE Total $\Sigma =$										
PCP's Signature					Print Name					Date