Whole Child Assessment- Version 3 for 7 – 11 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	□ Biological Parent(s) □ Step Parent(s) □ Adopted Parent(s) □ Foster Parent(s) □ Friend(s) □ Other *(specify)*				
2	Does your child go to daycare?		No	Unsure	Yes	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 give your child a bottle with anything other than breast milk, formula, or water?		Never	Sometimes	Often	9 Dental
10	What do you feed your child? *Circle all that apply.*		Breast milk	Formula	Milk	8 Nutrition
11	Has your child started eating solids?		Yes	Unsure	No	
12	Is your child enrolled in WIC?		Yes	Unsure	No	
13	Does your child watch anything on a TV, phone, computer, or tablet?		Never	Sometimes	Often	7 Physical Activity
14	Do you **always** put your baby to sleep on her/his back?		Yes	Unsure	No	6 Sleep
15	Is it difficult to put your child to sleep?		Rarely	Sometimes	Often	
16	Do you feel your child is difficult to take care of?		Never	Sometimes	Often	5 Relationships
17	Are your child's parents separated, divorced, or not living together?		No	Deceased parents / Unsure	Yes	
18	Does your family look out for each other, feel close to each other, and support each other?		Often	Sometimes	Never	
19	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	

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20	Is your child fussy or irritable?	Never	Sometimes		Often	4 Mental Health
21	Was a parent or household member **ever** depressed, mentally ill, **OR** suicidal?	No	Unsure		Yes	
22	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:
23	Does your child spend time with anyone who smokes, vapes, **OR** uses e-cigarettes?	No	Unsure		Yes	3 Substances
24	In the past year, how many times have **you** had 4 or more drinks containing alcohol **in one day**?	0	1		2+	
25	Did a parent or household member **ever** have a problem with drugs **OR** alcohol?	No	Unsure		Yes	
26	Does your home have a working smoke detector and carbon monoxide detector?	Yes	Unsure		No	2 Safety
27	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	Unsure		No	
28	Do you **always** stay with your child when she/he is in the bathtub?	Yes	Unsure		No	
29	Do you **always** place your child in a rear-facing car seat in the back seat?	Yes	Unsure		No	
30	Does your child spend time near a swimming pool, river, lake, or hot tub?	No	Unsure		Yes	
31	Does your child spend time in a home where a gun is kept?	No	Unsure		Yes	
32	Has your child **ever** seen or heard adults in the home pushing, hitting, kicking, **OR** physically threatening each other?	No	Unsure		Yes	
33	Has your child **ever** lived with a parent or other adult who physically hurt the child in anger?	No	Unsure		Yes	
34	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
35	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:	17	18	19	21	25	32	33	34	∑ =
Child-ACE Risks:	1	16	22A	22B	24				∑ =
								Child-ACE Total	∑ =

PCP's Signature	Print Name	Date