

Whole Child Assessment- Version 3 for 9 - 11 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>)									
2a.	What grade is your child in school?	K	1	2	3	4	5	6	7	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	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 or behavior? <i>If yes, please describe:</i>	No		Unsure				Yes			
6	<i>For girls only-</i> Has your daughter gotten her first period?	No		Unsure				Yes		10 Tuberculosis	
7	Has a family member or close contact had tuberculosis disease during your child's lifetime?	No		Unsure				Yes			
8	Was your child born in the United States?	Yes		Unsure				No			
9	Has your child lived or traveled outside of the United States for at least a month ?	No		Unsure				Yes			
10	Does your child brush her/his teeth twice daily with fluoride toothpaste?	Often		Sometimes				Never		9	
11	In the past year, has your child been seen twice by a dentist?	Yes		Unsure				No		Dental	
12	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	
13	How many servings of vegetables (about the size of your child's fist) does your child eat each day ?	4+		2-3				0-1			
14	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			
15	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+			
16	How many times a week does your child eat breakfast?	6-7		3-5				0-2			
17	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+			

**Whole Child Assessment- Version 3
for 9 - 11 Years**

18	How many times a week does your child snack on chips, pretzels, OR crackers?	0-1	2-3	4+	7 Physical Activity	
19	How many times a week does your child eat ice cream, cookies, OR other desserts?	0-1	2-3	4+		
20	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		
21	On those days that your child plays actively, how many minutes does she/he play?	60+	30-59	0-29		
22	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		
23	Is your child involved in sports, dance, music, religious activities, or other extracurriculars?	Yes	Unsure	No	6 Sleep	
24	Does your child have trouble falling asleep or staying asleep?	Never	Sometimes	Often		
25	Do you feel your child is difficult to take care of?	Never	Sometimes	Often		5 Relationships
26	Do you find you need to shout or yell at your child?	Never	Sometimes	Often		
27	Do you find you need to hit or spank your child?	Never	Sometimes	Often		
28	Are your child’s parents separated, divorced, or not living together?	No	Deceased parent	Unsure Yes		
29	Does your family look out for each other, feel close to each other, and support each other?	Often	Sometimes	Never		
30	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		4 Mental Health
31	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		
32	Does your child seem nervous or afraid?	Never	Sometimes	Often		
33	Does your child seem sad or unhappy?	Never	Sometimes	Often		
34	Does your child have trouble with anger or get into fights with other children?	Never	Sometimes	Often		
35	Does your child have trouble paying attention or sitting still?	Never	Sometimes	Often		
36	Was a parent or household member ever depressed, mentally ill, OR suicidal?	No	Unsure	Yes		
37	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 0 0 0 0	Several days 1 1 1 1	More than half the days 2 2 2 2	Nearly every day 3 3 3 3	A: B:
38	Does your child spend time with anyone who smokes, vapes, uses e-cigarettes, OR chews tobacco?	No	Unsure	Yes	3 Substances	
39	In the past year, how many times have you had 4 or more drinks containing alcohol in one day ?	0	1	2+		
40	Did a parent or household member ever have a problem with drugs OR alcohol?	No	Unsure	Yes		

**Whole Child Assessment- Version 3
for 9 - 11 Years**

41	Does your home have a working smoke detector and carbon monoxide detector?	Yes	Unsure	No	2 Safety		
42	Does your child always use a seat belt in the back seat (or use a booster seat if under 4'9")?	Yes	Unsure	No			
43	Does your child always wear a helmet when on a bike, skateboard, scooter, or roller blades?	Yes	Does not ride	No			
44	Does your child spend time near a swimming pool, river, lake, or hot tub?	No	Unsure	Yes			
45	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			
46	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			
47	Has your child ever lived with a parent or other adult who physically hurt the child in anger?	No	Unsure	Yes			
48	Has your child ever been bullied or cyber bullied, or felt unsafe at school or in your neighborhood?	No	Unsure	Yes			
49	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
50	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:	26	28	29	30	31	36	40	46	47	49	$\Sigma =$
Child-ACE Risks:	1	25	27	37A	37B	39					$\Sigma =$
Child-ACE Total $\Sigma =$											
PCP's Signature					Print Name					Date	