

Whole Child Assessment- Version 2 for 4 – 5 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 (specify)			
2	Is your child in preschool or school?	Yes	Unsure	No	1 Interval History
	Is your child in special ed?	No	Unsure	Yes	
3	Since the last visit, has your child				
	• 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	
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 health or behavior at home or school? <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	Does your child brush and floss 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 (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+	
19	Is your child enrolled in WIC?	Yes	Unsure	No	

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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	7 Physical Activity
21	On those days that your child plays actively, how many minutes does she/he play?	60+	30-59		0-29	
22	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	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	
36	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	
37	Does your child spend time with anyone who smokes, vapes, OR uses e-cigarettes?	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	Do you always place your child in a car seat or booster seat in the back seat?	Yes	Unsure		No	
42	Does your child always wear a helmet when on a bike, skateboard, scooter, or roller blades?	Yes	Does not ride		No	
43	Does your child spend time near a swimming pool, river, lake, or hot tub?	No	Unsure		Yes	

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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	2 Safety	
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

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:	25	27	28	29	30	35	39	45	46	48	$\sum =$
Child-ACE Risks:	1	24	26	36A	36B	38					$\sum =$
Child-ACE Total											$\sum =$
PCP's Signature				Print Name				Date			