"STAYING HEALTHY" ASSESSMENT
Pre-adolescents, 9–11 years of age

Patient Stamp

Patient Number _____ Plan Name/Number _____

If patient stamp not used, write in Patient and Plan Name/Number

Child's name (first, last)	Date of birth	Sex	Today's date
		❒ Male ❒ Female	
Your name	Relationship to child ❒ Parent ❒ Guardian ❒ Relative ❒ Friend ❒ Other		

For Clinical Use

Assistance needed:
Reading: ❒ **Yes** ❒ **No**
Interpreter: ❒ **Yes** ❒ **No**

You and your child's health care team can work together towards better health. Please answer these questions as best you can. You may check (✔) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your child's medical record.

Annual Review Date/Initials

Sample Question and Answer: Does your child go to school?	Yes ✔	No	Skip

Interventions Code/Date/Initials

Does Your Child:

1.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	No	Yes	Skip
2.	See the dentist at least once a year?	Yes	No	Skip
3.	Drink milk or eat yogurt or cheese at least 3 times each day?	Yes	No	Skip
4.	Eat fruits and vegetables every day?	Yes	No	Skip
5.	Eat only a limited amount of fried or fast foods?	Yes	No	Skip
6.	Play actively 5 days a week?	Yes	No	Skip
7.	Need to lose or gain weight?	No	Yes	Skip
8.	Often feel sad or depressed?	No	Yes	Skip
9.	Always wear a helmet when riding a bike or skateboard?	Yes	No	Skip
10.	Always wear a seatbelt when riding in a car?	Yes	No	Skip
11.	Spend time in a home where a gun is kept?	No	Yes	Skip

For Clinical Use

Intervention Codes: **C: Counseling** **EM: Educational Materials** **R: Referral** **F: Follow-up Needed** **SPN: See Progress Notes**

					For Clinical Use Interventions Code/Date/Initials
	Does Your Child:				
12.	Spend time with any friends who carry a gun, knife, club, or other weapon?	No	Yes	Skip	
13.	Spend time in a home with anyone who smokes?	No	Yes	Skip	
14.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	No	Yes	Skip	
	Has Your Child:				
15.	Ever smoked cigarettes or chewed tobacco?	No	Yes	Skip	
16.	Ever had alcohol such as beer, wine, wine coolers, or liquor?	No	Yes	Skip	
17.	Ever smoked marijuana, sniffed glue, or used street drugs?	No	Yes	Skip	
18.	Had friends or family members who had a problem with drugs or alcohol?	No	Yes	Skip	
19.	Started dating or "going with" boyfriends/girlfriends?	No	Yes	Skip	
20.	Become sexually active?	No	Yes	Skip	
21.	Ever been molested or sexually abused?	No	Yes	Skip	
22.	Ever witnessed or been a victim of physical abuse or violence?	No	Yes	Skip	
23.	Had problems at home or school?	No	Yes	Skip	
24.	**Do you have other questions or concerns about your child's health?** (Please identify) _____ _____ _____ _____	No	Yes	Skip	

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Privacy Statement

The Information Practices Act of 1977 (California Civil Code 1798) and the Federal Privacy Act (5 USC 552a, Subdivision (E)(3)) require this notice to be provided when collecting personal information from individuals. The information on this form is requested by your health care provider, health plan, and the Department of Health Services for purposes of providing health education services. Furnishing the information requested on this form is optional for the patient. Failure to provide the information requested will not result in any negative consequence for the patient. Information collected on this form is to be maintained in the patient's medical record, and is subject to the same medical and legal protection as other information maintained in the patient's medical record. State law and regulation including reporting requirements and protection of patient confidentiality applies to all information identified on this form. Within the constraints of these laws and regulations, certain information collected on this form may be transferred to state and local governmental and regulating agencies, contracted health plans, and health care providers.