HEALTHY START-FAMILY SPIRIT CHILD 1 YEAR ASSESSMENT

HSID:_ _ _ _ -_ _ _ _ -_ _ Date: (mm/dd/yyyy)_____ Staff:_____

Location of visit: ☐ Home ☐Office ☐ Other

Child's First Name: _____Child's Last Name:_____

☐ Change Client Contact Information (update if needed)
Current Address:_____ Phone_____ ☐ None
City:_____State_____ Zip Code_____ County_____

Current Age: _____ Meets CSHCN criteria? ☐ Yes, specify_____ ☐ No

Primary Insurance Coverage ☐ Medicaid ☐ MI-Child ☐Private ☐ None

Medical Home: ☐ Yes ☐ No
Medical Home Description:
☐Tribal Clinic ☐ Private Practice
☐ Hospital Based Primary Care Center ☐ Community Health Center (other than tribe)
☐ Other, Specify_____

Immunization Status:
☐Up to Date☐ Not up to date (needs catch-up) ☐ Waiver ☐ Cannot be ascertained

Is the child up to date on well-child visits?
☐ Up to Date ☐ Not up to date (needs visits) ☐ Cannot be ascertained ☐ Other, Specify_____

Has the child been to the Emergency Room in the past year? ☐ Yes. ☐ No
If yes how many times_____
Reason_____

Has the child received medical care for an injury or ingestion in past year? ☐ Yes. ☐ No
If yes how many times_____
Reason_____

Have any of the following heath & development issues been identified?

Asthma.	☐ Yes	☐ No	☐ Refused
HIV/AIDS	☐ Yes	☐ No	☐ Refused
Mental Health Issue (ASQ-SE).	☐ Yes	☐ No	☐ Refused
Failure to Thrive/ lack of growth (growth chart).	☐ Yes	☐ No	☐ Refused
Developmental Delay (ASQ-3)	☐ Yes	☐ No	☐ Refused
Other:_____	☐ Yes	☐ No	☐ Refused

Have any of the following Home Environment and Exposure issues been identified?

Family Violence/Intentional Injury	☐ Yes	☐ No	☐ Refused
Homelessness	☐ Yes	☐ No	☐ Refused
Unstable Housing	☐ Yes	☐ No	☐ Refused

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Unmet basic needs (food, diapers, ect.) ☐ Yes. ☐ No ☐ Refused
Live in or frequent visit house built before 1978 ☐ Yes ☐ No ☐ Refused
Peeling/chipping paint or remodeling underway ☐ Yes ☐ No ☐ Refused
Adult in house whose job/hobby involves Exposure to lead (auto repair, plumber, potter) ☐ Yes ☐ No ☐ Refused

Exposed to 2nd hand smoke in home ☐ Daily ☐ Weekly ☐ Monthly ☐ < Monthly ☐ Never
Rides in car with someone smoking ☐ Daily ☐ Weekly ☐ Monthly ☐ < Monthly ☐ Never

Where does your baby usually sleep?
☐ Crib ☐ In bed with someone ☐ On floor ☐ In a car seat ☐ Other_____

How often does your baby sleep in the same bed with you or someone else?
☐ Never ☐ Sometimes ☐ Most or every night/sleep times

Over the past year, how often have you or another adult in the household read to your child?
☐ Never ☐ Less than weekly ☐ 1-4 days/week ☐ Most 5 days/week to everyday

Referrals to Early Childhood or other Programs Made: ☐ Yes ☐ No ☐ Refused
If yes, referred to : ☐ Early Head Start/Head Start. ☐ Early On ☐ Tribal Child Program
☐ Other Day Care/ Child Care ☐ Other, specify _____