CHILD 1 YEAR ASSESSMENT

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

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

☐ Change Client Contact Information (update if needed; enter on client enter/edit screen)
Current Address:_____ Phone_____ ☐ None
City:_____State_____ Zip Code_____ County_____

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

*Is child up to date on immunizations?
☐ Yes ☐ No ☐ Unknown ☐ Refused

*Is child up to date on well child visits?
☐ Yes ☐ No ☐ Unknown ☐ Refused

*Has child been to the dentist?
☐ Yes ☐ No ☐ Unknown ☐ Refused
Staff: The American Academy of Pediatric Dentistry recommends that children start seeing a dentist every six months, by their first birthday or once their first tooth emerges

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

*Asthma.	☐ Yes ☐ No ☐ Refused
*HIV/AIDS	☐ Yes ☐ No ☐ Refused
*Mental Health Issue- (ASQ:SE-2 History)	☐ Yes ☐ No ☐ Refused
*Failure to Thrive/lack of growth (growth chart)	☐ Yes ☐ No ☐ Refused
*Developmental Delay(ASQ-3 History)	☐ Yes ☐ No ☐ Refused
Other, Specify_____	☐ Yes ☐ No ☐ Refused

*Does this child have a diagnosed developmental delay or disability?
☐ Yes ☐ No ☐ Unknown ☐ Refused

*Is child receiving Early Intervention Services/Care for a known issue? (Early On, speech therapy, physical therapy, other types of services based on the needs of child)
☐ Yes ☐ No ☐ Refused

*Is your child currently enrolled in Children's Special Health Care Services (CSHCS)? (Has qualifying medical condition. Note: CSHCS does not cover developmental, behavioral, or intellectual conditions)
☐ Yes ☐ No ☐ Refused

Have the following Home Environmental and Exposure Issues been identified?

*Family Violence/ Intentional Injury ☐ Yes ☐ No ☐ Refused

*Homelessness ☐ Yes ☐ No ☐ Refused

*Unstable Housing ☐ Yes ☐ No ☐ Refused

*Unmet Basic Needs (food, diapers, etc) ☐ Yes ☐ No ☐ Refused

*Live in or frequently 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 secondhand smoke in home?

☐ Daily ☐ Weekly ☐ Monthly ☐ > Monthly ☐ Never

*Rides in car with someone smoking?

☐ Daily ☐ Weekly ☐ Monthly ☐ > Monthly ☐ Never

*Do you have a car seat/booster seat for child? ☐ Yes ☐ No ☐ Refused

*Has this child ever been involved with Children's Protective Services?

☐ Yes ☐ No ☐ REFUSED

*Where does your child usually sleep?

☐Crib ☐In bed with someone ☐On floor ☐ Bassinette ☐ In Car Seat ☐ Own bed ☐ Other, specify_____

*How often does your child sleep in the same bed with you or someone else?

☐ Never ☐ Sometimes ☐ Most every night

*In what position do you lie your child down to sleep?

☐ Front ☐ Back ☐ Side

*How often have you or another adult in the household read, told stories, or sang songs with your child?

☐ Never ☐ Less than Weekly ☐ 1-4 days/week ☐ 5 days/week to everyday

Is this child still being breastfed? ☐ Yes ☐ No ☐ Never Breastfed ☐ Refused/Unknown

Duration of Breastfeeding (months) _____

If still breastfeeding, enter the child's current age.
If breastfeeding has ended, enter the child's age (in months) when breastfeeding stopped.

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 _____