

CHILD 3 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 second hand 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 Own bed Other, specify_____

*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 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 _____