

# CHILD 5 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*

Does this child currently attend kindergarten?  Yes  No

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 \_\_\_\_\_