State of California - Health and Human Services Agency **Department of Health Care Services**

Staying Healthy Assessment

7 - 12 Months

Today's Date

First Name **Middle Name / MI** **Last Name**

Date of Birth **Sex** **Person Completing Form** **Other**

- [ ] Parent
- [ ] Relative
- [ ] Friend
- [ ] Guardian
- [ ] Other

In Child/Day Care?

- ( ) Yes
- ( ) No

Need Help with Form?

- ( ) Yes
- ( ) No

Need Interpreter?

- ( ) Yes
- ( ) No

Please answer all the questions on this form as best you can. Select "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

1. Do you breastfeed your baby?

- ( ) Yes
- ( ) No
- ( ) Skip

2. Does your baby drink or eat 3 servings of calcium-rich foods daily, such as formula, breast milk, cheese, yogurt, soy milk, or tofu?

- ( ) Yes
- ( ) No
- ( ) Skip

3. Are you concerned about your baby's weight?

- ( ) Yes
- ( ) No
- ( ) Skip

4. Does your baby watch any TV?

- ( ) Yes
- ( ) No
- ( ) Skip

5. Does your home have a working smoke detector?

- ( ) Yes
- ( ) No
- ( ) Skip

6. Have you turned your water temperature down to low-warm (less than 120 degrees)?

- Yes
- No
- Skip

7. If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?

- Yes
- No
- Skip

8. Does your home have cleaning supplies, medicines, and matches locked away?

- Yes
- No
- Skip

9. Does your home have the phone number of the Poison Control center (800-222-1222) posted by your phone?

- Yes
- No
- Skip

10. Do you always put your baby to sleep on his/her back?

- Yes
- No
- Skip

11. Do you always stay with your baby when he/she is in the bathtub?

- Yes
- No
- Skip

12. Do you always place your baby in a rear facing car seat in the back seat?

- Yes
- No
- Skip

13. Is the car seat you use the right one for the age and size of your baby?

- Yes
- No
- Skip

14. Does your baby spend time near a swimming pool, river, or lake?

- Yes
- No
- Skip

15. Does your baby spend time in a home where a gun is kept?

- Yes
- No
- Skip

16. Do you give your baby a bottle with anything except formula, breast milk, or water?

- Yes
- No
- Skip

17. Does your baby spend time with anyone who smokes?

- Yes
- No
- Skip

18. Do you have any other questions or concerns about your baby's health, development, or behavior?

- Yes
- No
- Skip

If yes, please describe:

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