

		<i>For Clinical Use</i>		
		Interventions Code/Date/Initials		
Does Your Child:				
12.	Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
13.	Breastfeed?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
14.	Drink formula, milk, or eat yogurt at least 2 times each day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip
15.	Eat fruits and vegetables every day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Skip
16.	Eat foods that may cause choking such as nuts, popcorn, hotdogs, whole grapes, or hard candy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
17.	Spend time at a house or apartment complex with a swimming pool or hot tub?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
18.	Spend time in a home where a gun is kept?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
19.	Spend time in a home with anyone who smokes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
20.	Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
21.	Has your child ever witnessed or been a victim of abuse or violence?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip
22.	Do you have other questions or concerns about your child's health? (Please identify) _____ _____ _____ _____	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Skip

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Intervention Codes: C: Counseling EM: Educational Materials R: Referral F: Follow-up Needed SPN: See Progress Notes

Privacy Statement

The Information Practices Act of 1977 (California Civil Code 1798) and the Federal Privacy Act (5 USC 552a, Subdivision (E)(3)) require this notice to be provided when collecting personal information from individuals. The information on this form is requested by your health care provider, health plan, and the Department of Health Services for purposes of providing health education services. Furnishing the information requested on this form is optional for the patient. Failure to provide the information requested will not result in any negative consequence for the patient. Information collected on this form is to be maintained in the patient's medical record, and is subject to the same medical and legal protection as other information maintained in the patient's medical record. State law and regulation including reporting requirements and protection of patient confidentiality applies to all information identified on this form. Within the constraints of these laws and regulations, certain information collected on this form may be transferred to state and local governmental and regulating agencies, contracted health plans, and health care providers.