CHILD NAME:	**DATE OF BIRTH:**	**Does the patient have any allergies or reactions to medication, food, plants or insect bites? Please explain below.**
#1		
#2		
#3		

Who lives in the home? _____

Has the patient or anyone in patient's immediate family (SIBLINGS, PARENTS, MATERNAL GM/GF, PATERNAL GM/GF, ETC had or been treated for any of the following?

Please fill in the box with the following codes for whom the condition relates to:

P **Patient (P1=Child # 1 above, P2=Child #2, etc.**
M **Mother**
MGM **Maternal Grandmother**
MGF **Maternal Grandfather**
S **Sibling**
F **Father**
PGM **Paternal Grandmother**
PGF **Paternal Grandfather**
O **Other (please explain next to the conditon)**
Please explain where a line indicates

- ☐ Asthma Last attack: _____
- ☐ Diabetes
- ☐ Heart disease (e.g, CHF, CAD, MI, High Blood Pressure)_____
- ☐ Stroke / TIA
- ☐ Lung / respiratory disease _____
- ☐ Muscular / skeletal condition _____
- ☐ Psychiatric / psychological and emotional difficulties (e.g. ADD, ADHD, Asperger syndrome, autism) _____
- ☐ Bleeding disorders _____
- ☐ Fainting spells
- ☐ Thyroid disease _____
- ☐ Kidney disease _____
- ☐ Seizures Last Seisure: _____
- ☐ Sleep disorders (e.g. Sleep apnea) Use CPAP
- ☐ Abdominal / digestive problems _____
- ☐ Surgery _____
- ☐ Serious injury _____
- ☐ High cholesterol
- ☐ Addictions _____
- ☐ Cancer _____
- ☐ Other _____

DO ANY OF YOUR CHILDREN SEE OTHER PROVIDERS? IF YES,

Child Name: _____ Provider Name: _____

Child Name: _____ Provider Name: _____

FAMILY SAFETY CHECK

- ☐ Our family buckles up on every car ride.
- ☐ Our family wears bike helmets when bicycling.
- ☐ Kids under 10 never cross streets alone.
- ☐ Kids are always supervised in or near water
- ☐ Our home has working smoke detectors and we check the batteries monthly
- ☐ Our water heaters are set no higher than 120 F to prevent scald burns.
- ☐ If guns are in our home, they are kept unloaded and locked away. ***WE HAVE FREE GUN LOCKS AVAILABLE TO ANYONE WHO COULD USE THEM.**
- ☐ Kids are protected against falls from windows, stairs, furniture, and playground equipment.
- ☐ Household cleaners, medicines, and vitamins are stored out of young kid's reach
- ☐ Our home has emergency numbers posted and first aid supplies.

Parent/Guardian signature: _____ Date:_____

SOCIAL NEEDS SCREENING TOOL

Please answer the following.

HOUSING

1 **What is your housing situation today?**

- ☐ I do not have housing (I am staying with others, in a hotel, in shelter, living outside on the street, in a car, abandoned building, bus or train station, or in a park)
- ☐ I have housing today, but I am worried about losing housing in the future
- ☐ I have housing.

2 Think about the place you live. Do you have problems with any of the following? (check all that apply)

- ☐ Bug infestation
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ inadequate heat
- ☐ Oven or stove not working
- ☐ No or not working smoke detectors
- ☐ Water leaks
- ☐ None of the above

FOOD

3 **Within the past 12 months, you worried that your food would run out before you got money to buy more.**

- ☐ Often true
- ☐ sometimes true
- ☐ Never true

4 **Within the past 12 months, the food you bought just didn't last and didn't have money to get more**

- ☐ Often true
- ☐ sometimes true
- ☐ Never true

TRANSPORTATION

5 **In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? (check all that apply)**

- ☐ Yes, it has kept me from medical appointments or getting medications
- ☐ Yes, it has kept me from non-medical meeting, appointments, work or getting things that I need
- ☐ No

UTILITIES

6 **In the past 12 months, has the electric, gas, oil, or water company threated to shut off services in your home?**

- ☐ Yes
- ☐ No
- ☐ Already shut off

PERSONAL SAFETY

7 **How often does anyone, including family, physically hurt you?**

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

8 How often does anyone, including family, insult or talk down to you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

9 How often does anyone, including family, threaten you with harm?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

10 How often does anyone, including family, scream or curse at you?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Fairly often
- ☐ Frequently

ASSISTANCE

11 Would you like help with any of these needs?

- ☐ Yes
- ☐ No

REFERENCE:

1. Billoux A, Verlander K, Anthony S, and Alley D. National Academy of Medicine. Standardized screening for health-related social needs in clinical settings: the accountable health communities screening tool. National Academies Press, Washington DC https://nam.edu/wp-content/uploads/2017/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Setting.pdf Accessed November 14, 2017

CHILD NAME:	**DATE OF BIRTH:**	**Does the patient have any allergies or reactions to medication, food, plants or insect bites? Please explain below.**
#4		
#5		
#6		
#7		

DO ANY OF YOUR CHILDREN SEE OTHER PROVIDERS? IF YES,

Child Name: _____ Provider Name: _____

Child Name: _____ Provider Name: _____

Child Name: _____ Provider Name: _____

Child Name: _____ Provider Name: _____