Name:
ID#:

HOW AM I DOING?
YOUR CHILD 7 YEARS THROUGH 10 YEARS
RISK ASSESSMENT

If you have any questions or concerns about yourself or your child, please share these with your child's health care provider. We want to assist you with your needs anyway possible.

YES	NO	
☐	☐	1. Has your child had contact with a person with confirmed or suspected infectious tuberculosis? (Family member or associate in jail or prison)
☐	☐	2. Has your child had an x-ray or examination that may suggest tuberculosis?
☐	☐	3. Has your child emigrated from a foreign country where there is a history of tuberculosis? (Asia, Middle East, Africa, Latin America)
☐	☐	4. Has your child traveled to a foreign country or had contact with a native person from such a country where there is a history of tuberculosis?
☐	☐	5. Does your child have HIV/AIDS?
☐	☐	6. Has your child or does your child live in a group home, foster care, or orphanage?
☐	☐	7. Does your child participate in some form of physical activity for a total of 30 minutes each day?
☐	☐	8. Has your child ever experience feeling really down or depressed for more than a week at a time?
☐	☐	9. Has your child ever threatened to harm him/herself?
☐	☐	10. Are you concerned that someone will harm you or your child, or worry that you may harm someone?
☐	☐	11. Has your partner or someone important to you emotionally, physically, or sexually abused you or your child?

CIRCLE ALL THAT APPLY OF THE FOLLOWING:

12. Does your child or is your child attempting to **(circle all that apply for your child)**:

8YR. & 10 YR.

Become Aware of Others & Outside World;

Develop Personal Confidence in Self;

Have Same Sex Friends that Assume Greater Importance;

Seek Greater Independence from Family or is she/he

Easily Influenced by Peers?

13. What type of water does your child drink daily? **(circle all that apply for your child)**

City   Well   Cistern   Bottled Water

YES	NO	
☐	☐	14. Do you have concerns about your child's weight or eating habits?
☐	☐	15. Does your child follow a special diet or is on a prescribed medication?
☐	☐	16. Does your child eat or drink every day: **(circle all that apply)** Fried Foods Lunch Meats Soft Drinks Cake Cookies Chips
☐	☐	17. Does your child eat 6 servings of any of the following daily: bread, cereal, rice, or pasta?
☐	☐	18. Does your child eat 3 servings of vegetables each day?
☐	☐	19. Does your child eat 2 servings of fruit or drink 2 serving(s) of 100% fruit juice daily?
☐	☐	20. Does your child eat 2 servings of any of the following daily: meat (beef, pork, chicken, turkey), fish, soup, beans, eggs or peanut butter?
☐	☐	21. Does your child eat or drink 3 servings daily of any of the following: milk, cheese or yogurt?

QUESTIONS OR CONCERNS TO DISCUSS WITH YOUR HEALTH CARE PROVIDER:

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ENTIRE FORM REVIEWED AND UPDATED WITH PATIENT ON FOLLOWING DATES:
(SIGNATURE AND DATES REQUIRED)

____________________   ____________________

____________________   ____________________

____________________   ____________________

____________________   ____________________

Reference: Maternal and Child Health Bureau, *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*, National Center for Education in Maternal and Child Health, 1994, Arlington, VA.