#### 0-6 Months

Chile	Child's Name (first & last)  Date of Birth  Male				y's Date	Ir	In Child/Day Care?  Yes No	
Pers	on Completing Form	Parent Re Other (Specify		nd 🗌	Guardia		eed Help with Form?  Yes No	
an a	Please answer all the questions on this form as best you can. Circle "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						Skip	Clinic Use Only: Nutrition	
2	Are you concerned about your bal		No	Yes	Skip	Physical Activity		
3	Does your baby watch any TV?		No	Yes	Skip			
4	Does your home have a working s		Yes	No	Skip	Safety		
5	Have you turned your water temp (less than 120 degrees)?	erature down to lo	ow-warm	Yes	No	Skip		
6	If your home has more than one f guards on the windows and gates		safety	Yes	No	Skip		
7	Does your home have cleaning su matches locked away?	, and	Yes	No	Skip			
8	Does your home have the phone is Control Center (800-222-1222) p		Yes	No	Skip			
9	Do you always put your baby to sleep on her/his back?				No	Skip		
10	Do you always stay with your bal bathtub?	by when she/he is	in the	Yes	No	Skip		

11	Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Skip	
12	Is the car seat you use the right one for the age and size of your baby?	Yes	No	Skip	
13	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
14	Do you give your baby a bottle with anything except formula, milk, or water?	No	Yes	Skip	Dental Health
15	Does your baby spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
16	Do you have any other questions or concerns about your baby's health, development, or behavior?	No	Yes	Skip	Other Questions

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:				
Nutrition									
Physical Activity									
Safety									
☐ Dental Health									
☐ Tobacco Exposure					☐ Patient Declined the SHA				
PCP's Signature: Print Name:					Date:				

### 7 - 12 Months

Child's Name (first & last)  Date of Birth  Male					y's Date			d/Day Care? Yes □ No
Pers	on Completing Form	☐ Parent ☐ Re☐ Other (Specify		nd [	] Guardi			Help with Form? s
ansı	se answer all the questions on this fower or do not wish to answer. Be surthing on this form. Your answers wil	or if you have	questi	ions abo		an N	eed Interpreter?  Yes No  Clinic Use Only:	
1	Do you breastfeed your baby?		Yes	No	Ski	р	Nutrition	
2	Does your baby drink or eat 3 ser daily, such as formula, milk, chee tofu?			Yes	No	Ski	р	
3	Are you concerned about your ba		No	Yes	Ski		Physical Activity	
4	Does your baby watch any TV?		No	Yes	Ski	р		
5	Does your home have a working	smoke detector?		Yes	No	Ski	р	Safety
6	Have you turned your water temp (less than 120 degrees)?	perature down to lo	w-warm	Yes	No	Ski	р	
7	If your home has more than one f guards on the windows and gates	safety	Yes	No	Ski	р		
8	Does your home have cleaning su matches locked away?	, and	Yes	No	Ski	р		
9	Does your home have the phone of Control Center (800-222-1222) p		Yes	No	Ski	ip		
10	Do you always put your baby to s	sleep on her/his ba	ck?	Yes	No	Ski	ip	

11	Do you always stay with your baby when she/he 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?	No	Yes	Skip	
15	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
16	Do you give your baby a bottle with anything except formula, milk, or water?	No	Yes	Skip	Dental Health
17	Does your baby spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
18	Do you have any other questions or concerns about your baby's health, development or behavior?	No	Yes	Skip	Other Questions

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
Nutrition					
Physical Activity					
Safety					
Dental Health					
☐ Tobacco Exposure					☐ Patient Declined the SHA
PCP's Signature:		Print Nam	e:		Date:

#### 1 -2 Years

Chile	Child's Name (first & last)  Date of Birth  Female					e Ir	n Child/Day Care?	
			☐ Male				☐ Yes ☐ No	
Pers	on Completing Form	Parent Re	elative Fri	end 🔲	Guardia	an N	leed Help with Form?	
	Other (Specify)							
Please answer all the questions on this form as best you can. Circle "Skip" if you do not know  Need Interpre								
an a	nswer or do not wish to answer. Be sur	e to talk to the a	loctor if you h	ave que	estions a	ibout	Yes No	
anyl	thing on this form. Your answers will be	e protectea as po	iri oj your me	aicai re	ecoru.		Clinic Use Only:  Nutrition	
1	Do you breastfeed your child?			Yes	No	Skip		
2	Does your child drink or eat 3 servir daily, such as milk, cheese, yogurt,			Yes	No	Skip		
3	Does your child eat fruits and vegeta per day?	ables at least tw	o times	Yes	No	Skip		
4	Does your child eat high fat foods, sice cream, or pizza more than once p	ods, chips,	No	Yes	Skip			
5	Does your child drink more than one juice per day?	- 6 oz.) of	No	Yes	Skip			
6	Does your child drink soda, juice dr drinks, or other sweetened drinks m			No	Yes	Skip	e	
7	Does your child play actively most of	days of the wee	k?	Yes	No	Skip	Physical Activity	
8	Are you concerned about your child	s weight?		No	Yes	Skip		
9	Does your child watch TV or play v	rideo games?		No	Yes	Skip		
10	Does your home have a working sm	oke detector?		Yes	No	Skip	Safety	
11	Have you turned your water temper (less than 120 degrees)?	ow-warm	Yes	No	Skip			
12	If your home has more than one floo guards on the windows and gates fo	safety	Yes	No	Skip			
13	Does your home have cleaning support matches locked away?	s, and	Yes	No	Skip			
14	Does your home have the phone num Control Center (800-222-1222) pos			Yes	No	Skip		

			_		
15	Do you always stay with your child when she/he is in the bathtub?	Yes	No	Skip	
16	Do you always place your child in a rear facing car seat in the back seat?	Yes	No	Skip	
17	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
18	Do you always check for children before backing your car out?	Yes	No	Skip	
19	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
20	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
21	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
23	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
24	Do you have any other questions or concerns about your child's health, development or behavior?	No	Yes	Skip	Other Questions

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:			
Nutrition								
☐ Physical Activity								
Safety								
☐ Dental Health								
☐ Tobacco Exposure					☐ Patient Declined the SHA			
PCP's Signature		Pr	int Name:		Date:			
SHA ANNUAL REVIEW								
PCP's Signature		Pr	int Name:		Date:			

## 3 - 4 Years

Chil	d's Name (first & last)  Date of Birth	☐ Female ☐ Male	Toda	ay's Date	e In	Child/Day Care?  Yes No
Pers	son Completing Form Parent Other (Spec	ın Ne	eed Help with Form?			
an c	ase answer all the questions on this form as best you co answer or do not wish to answer. Be sure to talk to the thing on this form. Your answers will be protected as	have que	estions a		Need Interpreter?  Yes No  Clinic Use Only:	
1	Does your child drink or eat 3 servings of calcium daily, such as milk, cheese, yogurt, soy milk, or to	Yes	No	Skip	Nutrition	
2	Does your child eat fruits and vegetables at least per day?	two times	Yes	No	Skip	
3	Does your child eat high fat foods, such as fried fice cream, or pizza more than once per week?	oods, chips,	No	Yes	Skip	
4	Does your child drink more than one small cup (4 of juice per day?	No	Yes	Skip		
5	Does your child drink soda, juice drinks, sports d drinks, or other sweetened drinks more than once		No	Yes	Skip	
6	Does your child play actively most days of the we	eek?	Yes	No	Skip	Physical Activity
7	Are you concerned about your child's weight?		No	Yes	Skip	
8	Does your child watch TV or play video games le hours per day?	ess than 2	Yes	No	Skip	
9	Does your home have a working smoke detector?	,	Yes	No	Skip	Safety
10	Have you turned your water temperature down to (less than 120 degrees)?	low-warm	Yes	No	Skip	
11	If your home has more than one floor, do you have guards on the windows and gates for the stairs?	Yes	No	Skip		
12	Does your home have cleaning supplies, medicin matches locked away?	Yes	No	Skip		
13	Does your home have the phone number of the Po Control Center (800-222-1222) posted by your pl		Yes	No	Skip	
14	Do you always stay with your child when she/he bathtub?	is in the	Yes	No	Skip	

15	Do you always place your child in a forward facing car seat in the back seat?	Yes	No	Skip	
16	Is the car seat you use the right one for the age and size of your child?	Yes	No	Skip	
17	Do you always check for children before backing your car out?	Yes	No	Skip	
18	Does your child spend time near a swimming pool, river, or lake?	No	Yes	Skip	
19	Does your child spend time in a home where a gun is kept?	No	Yes	Skip	
20	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	
21	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
22	Do you help your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
23	Does your child spend time with anyone who smokes?		Yes	Skip	Tobacco Exposure
24	Do you have any other questions or concerns about your child's development, health or behavior?	No	Yes	Skip	Other Questions

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
Nutrition					
Physical Activity					
Safety					
☐ Dental Health					
☐ Tobacco Exposure					☐ Patient Declined the SHA
PCP's Signature		Pı	rint Name:		Date:
			SHA ANNUAL	REVIEW	
PCP's Signature		P	rint Name:		Date:
PCP's Signature		P	rint Name:		Date:

### 5 - 8 Years

Chil					Date	Grad	Grade in School?			
			☐ Male							
Pers	son Completing Form	Parent Rela	ative 🗌 Frien	d 🗌 Gua						
☐ Other (Specify) Regular? ☐ Ye										
	Please answer all the questions on this form as best you can. Circle "Skip" if you do not know Need Interpreter?									
	inswer or do not wish to answer ut anything on this form. Your o						☐ Yes ☐ No			
ubo						ccoru.	Clinic Use Only: Nutrition			
1	Does your child drink or eat a daily, such as milk, cheese, y			Yes	No	Skip				
2	Does your child eat fruits and per day?	d vegetables at leas	t two times	Yes	No	Skip				
3	Does your child eat high fat fi ice cream, or pizza more than		l foods, chips	' No	Yes	Skip				
4	Does your child drink more to juice per day?	han one small cup	No	Yes	Skip					
5	Does your child drink soda, j energy drinks, or other sweet week?		No	Yes	Skip					
6	Does your child exercise or pweek?	Yes	No	Skip	Physical Activity					
7	Are you concerned about you	ur child's weight?		No	Yes	Skip				
8	Does your child watch TV or hours per day?	r play video games	less than 2	Yes	No	Skip				
9	Does your home have a work	king smoke detecto	r?	Yes	No	Skip	Safety			
10	Have you turned your water (less than 120 degrees)?	temperature down	Yes	No	Skip					
11	Does your home have the ph Control Center (800-222-122		Yes	No	Skip					
12	Do you always place your ch seat (or use a seat belt if you		Yes	No	Skip					
13	Does your child spend time i lake?	near a swimming p	No	Yes	Skip					
14	Does your child spend time i	n a home where a	No	Yes	Skip					

15	Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes	Skip				
16	Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No	Skip	)			
17	Has your child ever witnessed or been victim of abuse or violence?	No	Yes	Skip				
18	Has your child been hit or hit someone in the past year?	No	Yes	Skip				
19	Has your child ever been bullied or felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip				
20	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health			
21	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health			
22	Does your child spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure			
23	Do you have any other questions or concerns about your child's health or behavior?	No	Yes	Skip	Other Questions			

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:			
Nutrition								
Physical Activity								
Safety								
☐ Dental Health								
☐ Tobacco Exposure					☐ Patient Declined the SHA			
PCP's Signature		Pr	int Name:		Date:			
			SHA ANNUAL	REVIEW				
PCP's Signature			int Name:		Date:			
PCP's Signature	Pr	int Name:		Date:				
PCP's Signature		Pr	int Name:		Date:			

### 9 - 11 Years

Child's Name (first & last)  Date of Birth  Male			Today's	Date	Grad	Grade in School:	
Pers	on Completing Form		ol Attendance ılar?				
Please answer all the questions on this form as best you can. Circle "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.  Need Interpre							
1	Does your child drink or eat 3 staily, such as milk, cheese, you			Yes	No	Skip	Nutrition
2	Does your child eat fruits and v per day?	vegetables at least	t two times	Yes	No	Skip	
3	Does your child eat high fat for ice cream, or pizza more than or		foods, chips,	No	Yes	Skip	
4	Does your child drink more that day?	an one cup (8 oz.)	of juice per	No	Yes	Skip	
5	Does your child drink soda, jui energy drinks, or other sweeter week?	No	Yes	Skip			
6	Does your child exercise or pla week?	Yes	No	Skip	Physical Activity		
7	Are you concerned about your	No	Yes	Skip			
8	Does your child watch TV or phours per day?	olay video games	less than 2	Yes	No	Skip	
9	Does your home have a working	ng smoke detector	r?	Yes	No	Skip	Safety
10	Does your home have the phor Control Center (800-222-1222			Yes	No	Skip	
11	Do your child always use a sea a booster seat if under 4'9")?	Yes	No	Skip			
12	Does your child spend time ne lake?	ar a swimming po	No	Yes	Skip		
13	Does your child spend time in	No	Yes	Skip			
14	Does your child spend time wi knife, or other weapon?	No	Yes	Skip			
15	Does your child always wear a skateboard, or scooter?	Yes	No	Skip			

16	Has your child ever witnessed or been a victim of abuse or violence?	No	Yes	Skip	
17	Has your child been hit or has your child hit someone in the past year?	No	Yes	Skip	
18	Has your child ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes	Skip	
19	Does your child brush and floss her/his teeth daily?	Yes	No	Skip	Dental Health
20	Does your child often seem sad or depressed?	No	Yes	Skip	Mental Health
21	Does your child spend time with anyone who smokes?	No	Yes	Skip	Alcohol, Tobacco, Drug Use
22	Has your child ever smoked cigarettes or chewed tobacco?	No	Yes	Skip	
23	Are you concerned your child may be using drugs or sniffing substances, such as glue, to get high?	No	Yes	Skip	
24	Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?	No	Yes	Skip	
25	Does your child have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Has your child started dating or "going out" with boyfriends or girlfriends?	No	Yes	Skip	Sexual Issues
27	Do you think your child might be sexually active?	No	Yes	Skip	
28	Do you have any other questions or concerns about your child's health or behavior?	No	Yes	Skip	Other Questions
	<i>W</i> 1 1 11	L	1	<u> </u>	

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:			
Nutrition								
Physical activity								
Safety								
Dental Health								
Mental Health								
Alcohol, Tobacco, Drug Use								
Sexual Issues					☐ Patient Declined the SHA			
PCP's Signature:		Print N	lame:		Date:			
		SH.	A ANNUAL R	FVIFW				
PCP's Signature:	Date:							
PCP's Signature:		Print N	lame:		Date:			

## 12 - 17 Years

Name (first & last)				Today's Date		Grade in School:	
	☐ Male		Male	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
Pers	on Completing Form	☐ Parent ☐ Rela	tive 🗌 Friend	☐ Gua	rdian	School Attendance	
	Regular	? No No					
Pleas	Need Interpreter?  Yes No						
	not wish to answer. Be sure to talk t answers will be protected as part of y		e questions about	unyunin	g on un.	s joi iii.	Clinic Use Only:
1	Do you drink or eat 3 servings of omilk, cheese, yogurt, soy milk, or		ily, such as	Yes	No	Skip	Nutrition
2	Do you eat fruits and vegetables a	t least 2 times per day	?	Yes	No	Skip	
3	Do you eat high fat foods, such as pizza more than once per week?			No	Yes	Skip	
4	Do you drink more than 12 oz. (1 sports drink, energy drink, or sweet		uice drink,	No	Yes	Skip	
5	Do you exercise or play sports mo	st days of the week?		Yes	No	Skip	Physical Activity
6	Are you concerned about your we	ight?		No	Yes	Skip	
7	Do you watch TV or play video ga	ames less than 2 hours	s per day?	Yes	No	Skip	
8	Does your home have a working s		Yes	No	Skip	Safety	
9	Does your home have the phone in (800-222-1222) posted by your ph	Yes	No	Skip			
10	Do you always wear a seatbelt wh	en riding in a car?		Yes	No	Skip	
11	Do you spend time in a home whe	ere a gun is kept?		No	Yes	Skip	
12	Do you spend time with anyone w weapon?			No	Yes	Skip	
13	Do you always wear a helmet who scooter?	en riding a bike, skate	board, or	Yes	No	Skip	
14	Have you ever witnessed abuse or	violence?		No	Yes	Skip	
15	Have you been hit, slapped, kicke (or have you hurt someone) in the	past year?		No	Yes	Skip	
16	Have you ever been bullied or fel- neighborhood (or been cyber-bull	n your	No	Yes	Skip		
17	Do you brush and floss your teeth		Yes	No	Skip	Dental Health	
18	Do you often feel sad, down, or hopeless?				Yes	Skip	Mental Health
19	Do you spend time with anyone w		No	Yes	Skip	Alcohol, Tobacco, Drug Use	
20	Do you smoke cigarettes or chew		No	Yes	Skip		
21	Do you use or sniff any substance cocaine, crack, Methamphetamine	No	Yes	Skip			

22	Do you use medicines not prescribed for you?	No	Yes	Skip	
23	Do you drink alcohol once a week or more?	No	Yes	Skip	
24	If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes	Skip	
25	Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes	Skip	
26	Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes	Skip	
You	ir answers about sex and family planning cannot be shared with anyone, inc	cluding y	our pare	nts, witho	
27	Have you ever been forced or pressured to have sex?	No	Yes	Skip	Sexual Issues
28	Have you ever had sex (oral, vaginal, or anal)? If no, skip to question 35.	No	Yes	Skip	
29	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
30	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
31	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
32	The last time you had sex, did you use birth control?	Yes	No	Skip	
33	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
34	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip	
35	Do you have concerns about liking someone of the same sex?	No	Yes	Skip	
36	Do you have any other questions or concerns about your health?	No	Yes	Skip	Other Questions

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
Nutrition					
☐ Physical activity					
Safety					
Dental Health					
☐ Mental Health					* # #
Alcohol, Tobacco, Drug Use					
☐ Sexual Issues					☐ Patient Declined the SHA
PCP's Signature:		Print Name:			Date:
Contract Library					
		the second secon	A ANNUAL REV	/IEW	Parker Bulletin Street
PCP's Signature:		Print Name			Date:
PCP's Signature:		Print Name			Date:
PCP's Signature:		Print Name			Date:
PCP's Signature:	Print Name			Date:	

### Adult

Patient's Name (first & last)  Date of Birth					male		То	day's Date
				□ Ма	ale			
Person Completing Form (if patient needs help)								ed help with form?
☐ Other (Specify) ☐ Yes ☐ No								
		se answer all the questions on this form as be ver or do not wish to answer. Be sure to talk					w an	Need Interpreter?
		ching on this form. Your answers will be prot						Yes No  Clinic Use Only:
	1	Do you drink or eat 3 servings of calciu such as milk, cheese, yogurt, soy milk,		ily,	Yes	No	Skip	Nutrition
	2	Do you eat fruits and vegetables every	day?		Yes	No	Skip	
	3	Do you limit the amount of fried food o eat?	or fast food that y	ou	Yes	No	Skip	
	4	Are you easily able to get enough health	hy food?		Yes	No	Skip	
	5	Do you drink a soda, juice drink, sports days of the week?	s or energy drink	most	No	Yes	Skip	
	6	Do you often eat too much or too little	No	Yes	Skip			
	7	Are you concerned about your weight?			No	Yes	Skip	
	8	Do you exercise or spend time doing ac walking, gardening, swimming for ½ ho		Yes	No	Skip	Physical Activity	
	9	Do you feel safe where you live?			Yes	No	Skip	Safety
	10	Have you had any car accidents lately?			No	Yes	Skip	
	11	Have you been hit, slapped, kicked, or p someone in the last year?	physically hurt b	У	No	Yes	Skip	
	12	Do you always wear a seat belt when driving or riding in a car?				No	Skip	
	13	Do you keep a gun in your house or pla	ace where you liv	re?	No	Yes	Skip	
	14	Do you brush and floss your teeth daily		Yes	No	Skip	Dental Health	
	15	Do you often feel sad, hopeless, angry, or worried?				Yes	Skip	Mental Health
	16	Do you often have trouble sleeping?		No	Yes	Skip		
	17	Do you smoke or chew tobacco?		No	Yes	Skip	Alcohol, Tobacco, Drug Use	
	18	Do friends or family members smoke in where you live?	No	Yes	Skip			

19	In the past year, have you had:  ☐ (men) 5 or more alcohol drinks in one day?  ☐ (women) 4 or more alcohol drinks in one day?	No	Yes	Skip	
20	Do you use any drugs or medicines to help you sleep, relax, calm down, feel better, or lose weight?	No	Yes	Skip	
21	Do you think you or your partner could be pregnant?	No	Yes	Skip	Sexual Issues
22	Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes	Skip	
23	Have you or your partner(s) had sex without using birth control in the past year?	No	Yes	Skip	
24	Have you or your partner(s) had sex with other people in the past year?	No	Yes	Skip	
25	Have you or your partner(s) had sex without a condom in the past year?	No	Yes	Skip	
26	Have you ever been forced or pressured to have sex?	No	Yes	Skip	
27	Do you have other questions or concerns about your health?	No	Yes	Skip	Other Questions
***************************************		· k	-A		A STREET, STRE

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:		
Nutrition							
☐ Physical activity							
Safety							
☐ Dental Health							
Mental Health							
Alcohol, Tobacco, Drug Use							
Sexual Issues					☐ Patient Declined the SHA		
PCP's Signature:		Print	Name:		Date:		
		5	IIA ANNIIIAI I	DEVIEW			
PCP's Signature:			HA ANNUAL I Name:	REVIEW	Date:		
PCP's Signature:		Print	Name:		Date:		
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PCP's Signature:	rre: Print Name:				Date:		
CP's Signature: Print			Name:		Date:		
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