WESTVIEW
PEDIATRIC CARE

CHILD'S NAME_____ Birthdate_____/_____/_____ Sex ___M____F

Alternate First Name:_____ Alternate Last Name:_____

Address _____ City_____ Zip Code_____

Social Security Number:_____

Insurance Company:_____ Insurance ID: _____ Group Number:_____

Please Circle

Race(s): American Indian/Alaskan Native Asian Black/African-American Hawaiian Native/Pacific Islander White

Ethnicity: Hispanic/Latino Not Hispanic/Latino Unknown Decline

Primary Language Spoken:_____

Mother's name _____ Birthdate____/____/____ Home #_____

Employer _____ Occupation_____ Work #_____

Mother's Social Security Number:_____

Father's name _____ Birthdate ____/____/____ Home #_____

Employer _____ Occupation_____ Work #_____

Father's Social Security Number:_____

Legal Guardian name_____ Email:_____

Relationship to patient_____ Social Security Number: _____

Emergency Contact _____ Phone #_____

Preferred contact method: _____ Home Phone _____ Cell Phone _____ Email _____ Mail

WESTVIEW
PEDIATRIC CARE

PATIENT AGREEMENT

AUTHORIZATION FOR MEDICAL TREATMENT

Office practice/Clinic personnel at this facility are hear by authorized to administer any medical, diagnostic or therapeutic treatment, as may be deemed necessary or advisable. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

DISCLOSURE OF INFORMATION

I understand that my medical records and billing information are made and retained by this Office/Clinic and are accessible to office personnel. Office/Clinic personnel may use and disclose medical information for operation, functions and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. This Office/Clinic and its medical staff are authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or self-insured employer group liable for any part of the Office Practice/Clinic's charges and to any health care provider who is or may become involved with my care. Oklahoma law requires that this office/clinic advise you that the **information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease, or related to mental health, or drug, substance or alcohol abuse**. By signing this agreement, you are consenting to such disclosure. Office Practice/Clinic personnel may release my general condition to family or friends who inquire about me by name.

ASSIGNMENT OF INSURANCE BENEFITS

I agree that physician benefits otherwise payable to the insured are to be made payable to the physicians(s) responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit card at the time of service.

PRECERTIFICATION POLICY

I understand that this Office/Clinic will assist with insurance precertification, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONISBILITY

As consideration for the services provided, I (the parent or responsible party) guarantee payment for any amount due for such services provided by this Office Practice/Clinic.

CERTIFICATION

I hereby certify that I have read each of the above statement, have had each item explained to me my satisfaction, and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement. A photocopy of this document has the same effect as an original.

_____	_____	_____	_____
Parent or Legal Guardian	Relationship to Patient	Date	Witness

_____

Patient Name – Please Print

WESTVIEW
PEDIATRIC CARE

STATEMENT OF PERMISSION TO TREAT

DATE:

I, _____ the parent/guardian of

_____ give permission to the following person(s) to obtain treatment for the above named child through Westview Pediatric Care in the event of my absence. This person(s) has my permission for medical decision making including but not limited to: administration of medication, diagnostic or therapeutic procedures, admission to the hospital, etc.

NAME	RELATIONSHIP
_____	_____
_____	_____

_____

Parent/Guardian Signature

WESTVIEW PEDIATRIC CARE
NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: NOVEMBER 5, 2012

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time you visit a hospital, physician, dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care. Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. **Receive a copy of this Notice of Privacy Practices** from us upon enrollment or upon request.
2. **Request restrictions on our uses and disclosures of your protected health information** for treatment, payment and health care operations. This includes your right to request that we not disclose your health information to a health plan for payment or health care operations if you have paid in full and out of pocket for the services provided. We reserve the right not to agree to a given requested restriction.
3. **Request to receive communications of protected health information in confidence.**
4. **Inspect and obtain a copy of the protected health information** contained in your medical and billing records and in any other Practice records used by us to make decisions about you. If we maintain or use electronic health records, you will also have the right to obtain a copy or forward a copy of your electronic health record to a third party. A reasonable copying/labor charge may apply.
5. **Request an amendment to your protected health information**. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
   - was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - is not part of your medical or billing records;
   - is not available for inspection as set forth above; or
   - is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. **Receive an accounting of disclosures of protected health information** made by us to individuals or entities other than to you, except for disclosures:
   - to carry out treatment, payment and health care operations as provided above;
   - to persons involved in your care or for other notification purposes as provided by law;
   - to correctional institutions or law enforcement officials as provided by law;
   - for national security or intelligence purposes;
   - that occurred prior to the date of compliance with privacy standards (April 14, 2003);
   - incidental to other permissible uses or disclosures;
   - that are part of a limited data set (does not contain protected health information that directly identifies individuals);
   - made to patient or their personal representatives;
   - for which a written authorization form from the patient has been received
7. **Revoke your authorization to use or disclose health information** except to the extent that we have already been taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. **Receive notification if affected by a breach of unsecured PHI**

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

Treatment: We may use and disclose protected health information in the provision, coordination, or management of your health care, including consultations between health care providers regarding your care and referrals for health care from one health care provider to another.

Payment: We may use and disclose protected health information to obtain reimbursement for the health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Regular Healthcare Operations: We may use and disclose protected health information to support functions of our practice related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, physician reviews, compliance programs, audits, business planning, development, management and administrative activities.

Appointment Reminders: We may use and disclose protected health information to contact you to provide appointment reminders.

Treatment Alternatives: We may use and disclose protected health information to tell you about or recommend possible treatment alternatives or other health related benefits and services that may be of interest to you

Health-Related Benefits and Services: We may use and disclose protected health information to tell you about health-related benefits, services, or medical education classes that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location, general condition or death.

Business Associates: There may be some services provided in our organization through contracts with Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.

Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.

Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.

Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.

Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.

Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Fund raising: Unless you notify us you object, we may contact you as part of a fund raising effort for our practice. You may opt out of receiving fund raising materials by notifying the practice's privacy officer at any time at the telephone number or the address at the end of this document. This will also be documented and described in any fund raising material you receive.

Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.

Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.

Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Research (inpatient): We may disclose information to researchers when an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved their research.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a Web site that provides information about our patient/customer services or benefits, the new notice will be posted on that Web site.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice. Except as noted above, you may revoke your authorization in writing at any time.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our Privacy Officer, Eric Woodard, at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer at Westview Pediatric Care or with the Secretary of the Department of Health and Human Services. The complaint must be in writing, describe the acts or omissions that you believe violate your privacy rights, and be filed within 180 days of when you knew or should have known that the act or omission occurred. We will take no retaliatory action against you if you make such complaints.

The contact information for both is included below.

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Tel: (202) 619-0257
Toll Free: 1-877-696-6775
http://www.hhs.gov/contacts

Westview Pediatric Care
Eric Woodard
Privacy Officer
3606 N. MLK Jr. Blvd
(918) 428-5373
(918) 428-5376

NOTICE OF PRIVACY PRACTICES AVAILABILITY

This notice will be prominently posted in the office where registration occurs. You will be provided a hard copy, at the time we first deliver services to you. Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's Web site (if applicable Web site exists) for downloading.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A complete description of how your medical information will be used and disclosed by this Office/Clinic is in our NOITCE OF PRIVACY PRACTICES, which you have received. A Copy is posted in this Office/ Clinic.

I have received a copy of Notice of Privacy Practices.

_____ _____ _____

_____

Parent or Legal Guardian Relationship to Patient Date

Witness

Initial History Questionnaire

Name

ID NUMBER

FORM COMPLETED BY

DATE COMPLETED

BIRTH DATE

AGE

☐ M ☐ F

Household

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody

☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ☐ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Do you feel your family has enough to eat? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Asthma	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Kidney disease	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Obesity	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Drug abuse	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Developmental disability	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tobacco use	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When _____
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain _____
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain _____
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain _____
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain _____
HIV	☐ Yes	☐ No	☐ DK	Explain _____
Organ transplant	☐ Yes	☐ No	☐ DK	Explain _____
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain _____
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain _____
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain _____
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain _____
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain _____
Cancer	☐ Yes	☐ No	☐ DK	Explain _____
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain _____
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain _____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain _____
Obesity	☐ Yes	☐ No	☐ DK	Explain _____
Diabetes	☐ Yes	☐ No	☐ DK	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain _____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain _____
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain _____
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain _____
Tobacco use	☐ Yes	☐ No	☐ DK	Explain _____
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain _____
Developmental delay	☐ Yes	☐ No	☐ DK	Explain _____
Dental decay	☐ Yes	☐ No	☐ DK	Explain _____
History of family violence	☐ Yes	☐ No	☐ DK	Explain _____
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain _____
Pregnancy	☐ Yes	☐ No	☐ DK	Explain _____
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain _____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* 3rd Edition.

HE0328

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WESTVIEW
PEDIATRIC CARE

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name and Address of Individual/Facility/Company to Receive PHI:

_____

_____

_____

Name and Address of Individual/Facility to disclose PHI:

_____

_____

_____

Information authorized for use or disclosure, or to be obtained: [ ] History & Physical [ ] Discharge Summary [ ] Operative Report [ ] ER Record [ ] Consultation [ ] Lab reports [ ] Progress Notes [ ] X-ray reports [ ] Other:_____

Medical information between _____ to _____

The information will be obtained, used, or disclosed for the following purpose only:

[ ] Insurance [ ] Continued treatment [ ] Legal [ ] At patient or patient's representative request [ ] Other: _____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoke, the automatic expiration date will be six (6) months from date of signature or upon occurrence of the following event: _____.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease and may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses also known as Acquired immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Personal Representative **Date**

_____
Description of Representatives Authority to Act for the Patient

Notice of Rights: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it can not contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court of the Department of Health or by the law.

Processed by (Print Name): _____

PLEASE TAKE A BRIEF MOMENT TO TELL US HOW YOU HEARD ABOUT US!

_____ Radio advertisement

_____ Banner outside

_____ Driving by

_____ Other Siblings are patient's

_____ Inside Westview Medical Center

_____ Church:_____

_____ Insurance Company: _____

_____ Another Physician referred me: _____

_____ Sports Physical Sign

_____ Word of Mouth

_____ Brochure: where _____

_____ Facebook

Other: _____

THANK FOR CHOOSING WESTVIEW PEDIATRIC CARE

HealthySteps
PEDIATRIC CARE • SUPPORTING • PARENTING
A Program of ZERO TO THREE

HealthySteps Family Needs Questionnaire

Name: _____ Date: _____

Your family's health and well-being are important to us. Research tells us that stress can affect your health and your child's development. Please take a few minutes to answer the following questions. Your responses will help us better understand how we can best support you, your child, and your family. Thank you!

	Family Questionnaire	YES/NO (please circle one)	
1.	Within the past 12 months, you worried whether your food would run out before you got money to buy more.	Y	N
2.	Within the past 12 months, the food you bought just didn't last, and you didn't have money to get more.	Y	N
3.	Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as a part of a household?	Y	N
4.	In the past year, has the utility company shut off your service for not paying your bills?	Y	N
5.	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	Y	N
6.	Are you afraid you might be hurt in your apartment building or house? [1]	Y	N
7.	Does anyone in your household smoke or use any other tobacco products?	Y	N
8.	In the last year, have you ever drunk or used drugs more than you meant to? [2]	Y	N
9.	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?[2]	Y	N
10.	If you circled YES in any boxes above, would you like to receive assistance with any of these needs?	Y	N
11.	Are any of your needs urgent? For example: We don't have food tonight; we don't have a place to sleep tonight; I'm afraid for my safety.	Y	N
12.	Is there anything else you'd like to discuss today?	Y	N

[1] "Apartment building or house" should be understood as a person's current living situation (i.e., the person does not have to reside specifically in an apartment or house to respond).

[2] Reprinted with permission from Dr. Richard Brown.

The following questions allow us to learn even more about you, your baby, and your family. Please answer as many as possible if you have the time and/or desire.

13.	During the last 4 weeks, have you been actively looking for work?	☐ Y	☐ N
14.	Do problems getting child care make it difficult for you to work or study?	☐ Y	☐ N
15.	Have you (or anyone in your household) ever served on active duty in the U.S. Armed Forces?	☐ Y	☐ N
16.	In the last 12 months, did you visit a doctor for your own routine check-up (i.e., not a sick visit, specialist visit, or prenatal care appointment)?	☐ Y	☐ N
17.	Are you or your partner currently trying to, or thinking about trying to, get pregnant within the next 12 months?	☐ Y	☐ N
17a.	If not, would you like a referral to family planning services?	☐ Y	☐ N
18.	During the past 12 months, have you had a flu shot?	☐ Y	☐ N
19.	Have you had at least one dental exam in the last 12 months?	☐ Y	☐ N
20.	Has your child had at least one dental exam in the last 12 months? ☐ Yes ☐ No ☐ N/A, my child is younger than 1 year old		
21.	Does your home have a smoke detector?	☐ Y	☐ N
22.	If there is a gun at home, is it locked up? ☐ Yes ☐ No ☐ N/A, there are no guns in the home		
23.	Do you want anyone to check how your car seat is installed?	☐ Y	☐ N
24.	In which one position do you most often lay your baby (0-12 months old) down to sleep? ☐ On her/his back ☐ On her/his stomach ☐ On her/his side ☐ N/A, my child is older than 12 months		
25.	During the past week, how many days did you or other family members read to this child? ☐ 0 days ☐ 1 – 3 days ☐ 4 – 6 days ☐ Everyday		
26.	During the past week, how many days did you or other family members tell stories or sing songs to this child? ☐ 0 days ☐ 1 – 3 days ☐ 4 – 6 days ☐ Everyday		
27.	How old was this child when he or she was first fed anything other than breast milk or formula? _____ months _____N/A, my child is still exclusively breast- and/or formula-fed		
28.	Do you have a person (or people) you can see or talk to when you feel stressed or need advice (for example, friends, family, church members, people at a community center or club)? ☐ Yes ☐ No		
29.	What does your family do together for fun?		
30.	What are you finding most challenging about parenting?		
31.	What are 3 things you enjoy most about your baby/toddler?		