Sentinel Injury Psychosocial Assessment Form

We are going to ask you some questions today. We ask these questions of all families with an infant under 6 months of age who has any type of injury whether or not we are concerned.

Patient's Name: ____ **MRN:** ______________ **Age:** _____ months

Who is providing the information? ____ **Date:** ____________

Who lives with or is often in the child's home?

Age/gender of siblings/children in the home: ____

Age/gender of adults in the home: ____

Has an adult moved into or out of the child's home in the past 6 months? ☐ No ☐ Yes (Who? __________)

Do you have a partner or spouse? ☐ No ☐ Yes (How long have you been together? ____ months/years)

What is the child's ambulatory stage?
☐ Non-mobile ☐ Rolling over ☐ Sitting ☐ Crawling ☐ Pulling to stand ☐ Cruising

What is your child care arrangement? ☐ Stay at home parent (Which parent? ________________________)
☐ Babysitter (Who/Relation? ________________________) ☐ In Home Daycare (Where? ______________)
☐ Center Based Daycare (Where?____)

What was the child care arrangement on the date of the injury? ____________________________________

How would you describe your child's personality? ____

____

Do you often feel your child is difficult to take care of?	☐ Yes	☐ No
Do you or anyone at home sometimes find the need to hit or spank your child?	☐ Yes	☐ No
Do you wish you had more help with your child?	☐ Yes	☐ No
Do you often feel under extreme stress?	☐ Yes	☐ No
Have you or anyone at home often felt down, depressed, or hopeless in the past month?	☐ Yes	☐ No
Have you felt very little interest or pleasure in things you used to enjoy in the past month?	☐ Yes	☐ No

I would like to learn more about your child's home environment.

Have you or anyone who lives in the home been involved with Social Services?	☐ Yes	☐ No
Have you or anyone who lives in the home been involved with the police?	☐ Yes	☐ No
Do you or anyone who lives in the home use drugs?	☐ Yes	☐ No
Do you or anyone who lives in the home have a problem with alcohol?	☐ Yes	☐ No
Do you or anyone who lives in the home have a mental health problem?	☐ Yes	☐ No
Do you ever feel unsafe in your current relationship?	☐ Yes	☐ No
Has there been violence in your home in the past year (domestic or interpersonal)?	☐ Yes	☐ No
Have you or anyone who lives in the home hurt a pet or animal on purpose?	☐ Yes	☐ No
Do you worry that your food will run out before you get money/Food Stamps to buy more?	☐ Yes	☐ No
Are there any other problems you would like help with today?	☐ Yes	☐ No

To be completed by the person performing the assessment:

Please provide further information on any "yes" responses above.

List any resources provided: ____

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