Screening Tool:
Ages Birth to 1 Year

Today's Date: _____ / _____ / _____
Age of Child at Visit: _____ Months/Year **(circle)**
How many children live in the home? _____
CIRCLE ANSWERS BELOW (select all that apply):
Race of Patient: American Indian/Alaska Native; Asian; Black/African American; Native Hawaiian/other Pacific Islander; White; Unknown/Prefer Not to Answer;
Other:_____
Ethnicity of Patient: Hispanic or Latinx; Non-Hispanic or Latinx; Unknown/Prefer Not to Answer
Insurance Payer: Commercial/Private; Medicaid; Self-pay/Uninsured;
Other: _____

Being a parent is not always easy. We want to help families have a safe environment for kids. So, we're asking everyone these questions about problems that affect many families. If there's a problem, we'll try to help.
Please answer the questions about your child being seen today for a checkup. If there's more than one child, please answer "yes" if it applies to any one of them. This is voluntary. You don't have to answer any question you don't want to.

Shaded Area For Office Use Only		***For Caregiver Response***
Counseling Suggested	**Discussed?** If suggested	**Please check the box that most closely matches your feelings, behaviors, or needs.**
	□ Yes □ No	1. Would you like help finding a job or employment? □ Yes □ No
	□ Yes □ No	2. Would you like help finding daycare for your child? □ Yes □ No
	□ Yes □ No	3. Do you have trouble paying utilities or maintaining a safe place to live? □ Yes □ No
	□ Yes □ No	4. In the past 12 months, did you worry that your food would run out before you could buy more? □ Yes □ No
	□ Yes □ No	5. In the past 12 months, did the food you bought just not last and you didn't have money to get more? □ Yes □ No
	□ Yes □ No	6. Do you sometimes find you need to slap or hit your child? □ Yes □ No
	□ Yes □ No	7. Do you wish you had more help with your child? □ Yes □ No
	□ Yes □ No	8. Do you often feel under extreme stress? □ Yes □ No
	□ Yes □ No	9. Over the past 2 weeks, have you often felt down, depressed, or hopeless? □ Yes □ No
	□ Yes □ No	10. Over the past 2 weeks, have you felt very little interest or pleasure in things? □ Yes □ No
	□ Yes □ No	11. Thinking about the past 3 months, has a partner threatened, shoved, hit or kicked you or hurt you physically in any way? □ Yes □ No
	□ Yes □ No	12. Thinking about the past 3 months, have you had 4 or more drinks in one day? □ Yes □ No
	□ Yes □ No	13. Thinking about the past 3 months, have you, or another person in your household, used a recreational drug or a prescription medication for non-medical reasons? □ Yes □ No

Please complete then give this form back to the provider or staff you're seeing today. Thank you!

This tool is the property of the Ohio Chapter, American Academy of Pediatrics, and is for implementation as part of the Ohio AAP's Injury+SEEK Learning Collaborative only.
The SEEK Parent Questionnaire is © 2020, University of Maryland School of Medicine. Contact bpowell@ohioaap.org with questions.

Counseling Suggested	Discussed? If suggested	Please check the box that most closely matches your feelings, behaviors, or needs.
	□ Yes □ No	14. In what seat and direction does your child usually ride when in a car? □ Front seat - facing forward □ Front seat - facing backward □ Back seat - facing forward □ Back seat - facing backward
	□ Yes □ No	15. Do you ever sleep with your child in an adult bed or on a couch at nap or night? □ Yes □ No
	□ Yes □ No	16. Do you always place your child to sleep on their back for nap and night? □ Yes □ No
	□ Yes □ No	17. Does your child ever sleep with objects (like crib bumpers, pillows, blankets, stuffed animals, toys) in their crib? □ Yes □ No
	□ Yes □ No	18. Does anyone smoke at home? □ Yes □ No
	□ Yes □ No	19. Do you have a smoke detector and a carbon monoxide alarm for your home? □ Yes □ No
	□ Yes □ No	20. Have you taken a course in child lifesaving techniques, such as CPR or First Aid, within the past 3 years? □ Yes □ No
	□ Yes □ No	21. Some types of furniture have the potential to tip over when a child pulls on it or attempts to climb it (like dressers, TVs). Are all such pieces of furniture in your home secured to the wall? □ Yes □ No
	□ Yes □ No	22. Are there any situations in which you would consider leaving your child alone on a changing table, couch, bed, or similar surface? (Such as to answer the phone or grab something you need). □ Yes □ No
	□ Yes □ No	23. Do you ever hold your child while drinking hot liquids (like while standing, sitting or walking)? □ Yes □ No
	□ Yes □ No	24. How likely is your child to get small objects like toy parts, coins, watch batteries, & small pieces of food into their hands? (Consider the possibility of older children leaving these lying around or that your child could reach them somewhere.) □ Not at all likely □ Slightly likely □ Moderately likely □ Very likely
	□ Yes □ No	25. Are all medications, vitamins and potentially harmful household cleaners in your home secured with safety caps OR out of the reach of children? □ Yes □ No
	□ Yes □ No	26. Do you know how to contact the Poison Control Center (1-800-222-1222) if your child unintentionally ingests medications, vitamins and other harmful household cleaners/products? □ Yes □ No
	□ Yes □ No	27. If you have firearms in the home, are they all unloaded AND in locked storage? □ Yes □ No □ Does not apply to my house □ I prefer not to answer
	□ Yes □ No	28. If you have marijuana in the home, is it in locked storage? □ Yes □ No □ Does not apply to my house □ I prefer not to answer

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Were any of the following resources provided?

□ Ohio AAP Handout
□ Other Handout
□ Tangible Resource (e.g., cabinet lock, furniture anchor, sleep sack)
□ Other Resource
□ No Resource

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