Health Risk Screening (Age 6 months – 17 years)

Please answer all the questions. Use a different form for each child.

First Name _____ Last Name _____

Date of Birth _____ Member ID # _____

Preferred Mailing Address _____

_____

Preferred Phone Number _____ Preferred Email _____

Race
☐ Asian
☐ White
☐ Unknown
☐ Decline to answer
☐ American Indian/Alaska Native
☐ Black/African American
☐ Native Hawaiian/Pacific Islander
☐ Other _____

Ethnicity
☐ Hispanic or Latino
☐ Not Hispanic or Latino
☐ Decline to answer
☐ Unknown
☐ Other _____

Preferred Language
☐ English
☐ Spanish
☐ Unknown
☐ Other _____

Is your child American Indian?
☐ Yes ☐ No ☐ Unknown ☐ Decline to answer

If yes, is your child eligible to receive Indian Health Services?
☐ Yes ☐ No ☐ Unknown ☐ Decline to answer

What is your child's gender identity?
☐ Female ☐ Male ☐ Non-binary (Don't identify as either) ☐ Transgender ☐ Unknown ☐ Decline to answer

Does your child have any problems with your hearing, vision, or speech requiring special services? ☐ Yes ☐ No ☐ Unknown ☐ Decline to answer

If yes, please explain: _____

GENERAL HEALTH AND SAFETY

In general, how would you rate your child's health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor ☐ Unknown

If poor, please explain: _____

On a scale from 0-10, how ready are you to make changes for your child's health?
☐ 0-3 Not ready to change ☐ 4-7 Unsure ☐ 8-10 Ready for change ☐ No changes needed ☐ Unknown

If you are ready for a change, what changes are you ready to make for your child's health?

_____

Does your child have a doctor or health care provider?

☐ Yes What is your child's provider's name? _____

☐ Unknown ☐ No If no, would you like help finding a provider? ☐ Yes ☐ No

Has your child gone to all their recommended visits in the last year? (At least yearly or more often if your child is under age 3.) ☐ Yes ☐ No ☐ Unknown

ⓘ Regular wellness exams can help make sure your child stays as healthy as they can.

What is your child's age? ☐ 6 months to 3 years ☐ 4 to 10 years old

☐ Female, 11 to 15 years old ☐ Female, 16 to 17 years old ☐ Male, 11 to 17 years old ☐ Unknown

Has your child had at least one lead screening before the age of 2? (Answer only if age 6 months to 3 years old.)

☐ Yes ☐ No ☐ Unknown

Are your child's immunizations up to date? ☐ Yes ☐ No ☐ Unknown

Has your child had the following vaccines? (Answer only if 11 to 17 years old.)

Meningococcal (meningitis vaccine)	☐ Yes	☐ No	☐ Unknown
Tetanus shot since they turned 10 years old	☐ Yes	☐ No	☐ Unknown
HPV (cancer prevention) vaccine series – at least ONE dose	☐ Yes	☐ No	☐ Unknown
HPV (cancer prevention) vaccine series – at least TWO doses	☐ Yes	☐ No	☐ Unknown

Do you suspect that your child may be sexually active now or has been in the past? (Answer only if female 16 to 17 years old.) ☐ Yes ☐ No ☐ Unknown

If yes, has your child been tested in the last year for sexually transmitted infections (STI) like Chlamydia? ☐ Yes ☐ No ☐ Unknown

If yes, where and when did the Chlamydia testing take place? _____

Is your child pregnant? ☐ Yes, due date is _____ ☐ No ☐ Unknown

Has your child received a flu shot in the last 12 months? ☐ Yes ☐ No ☐ Unknown

ⓘ Flu shots are recommended for everyone over 6 months of age every year. Getting an annual flu shot is the best way to protect yourself and your family from the flu.

How many times has your child been in the hospital in the last 3 months?

☐ None ☐ One time ☐ Two times ☐ Three or more times ☐ Unknown

How many times has your child been in the emergency room (ER) in the last 3 months?

☐ None ☐ One time ☐ Two times ☐ Three or more times ☐ Unknown

How many medicines is your child currently taking that were prescribed by their doctor or provider?
☐ 0 prescriptions ☐ 1 to 3 prescriptions ☐ 4 to 7 prescriptions ☐ 8 or more prescriptions ☐ Unknown

Does anything prevent your child from taking their medicines the way their doctor or health care provider want them to? ☐ Yes ☐ No ☐ Unknown

If yes, what prevents your child from taking their medicine? _____

Do you ever forget to give your child their medicine? ☐ Yes ☐ No ☐ Sometimes ☐ Unknown

When was the last time your child saw a dentist? (Answer only if age 4 years or older.)
☐ Past 6 months ☐ Past 12 months ☐ More than a year ☐ Never seen a dentist ☐ Unknown

ⓘ Routine dental care is important for your child's oral (dental) and physical health.

What is your child's height? (Answer only if age 4 years or older.) _____ feet _____ inches

What is your child's weight? (Answer only if age 4 years or older.) _____ pounds

Have you or a doctor or provider been concerned about your child's weight? (Answer only if age 4 years or older.)
☐ Yes, overweight ☐ Yes, underweight ☐ No ☐ Unknown

If you said yes to a concern about being overweight, are you interested in working toward a healthier weight for your child? ☐ Yes ☐ No ☐ Unknown

Does your child eat a healthy diet, such as eating fruits, vegetables, and whole grains every day? Do they limit sugar and saturated fats? (Answer only if age 4 years or older.)
☐ Yes, most of the time ☐ Yes, sometimes ☐ No, not very often ☐ Unknown

Does your child participate in regular physical activity? (Answer only if age 4 years or older.)
☐ Yes ☐ No ☐ Unable to exercise due to medical reasons ☐ Unknown

ⓘ Regular physical activity helps improve overall health and fitness. It can also lower the risk for many chronic diseases. Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

Does your child always use a seat belt or sit in a car seat when you drive or ride in a car?
☐ Yes ☐ No ☐ Unknown

ⓘ Seat belt and car seat use is one of the best ways to save lives and reduce injuries in crashes.

Does your child always wear a helmet when riding a bike, scooter, etc.? (Answer only if age 4 years or older.)
☐ Yes ☐ No ☐ Unknown

ⓘ Wearing a helmet is one of the best ways to reduce head injuries.

Does your child live with anyone who is a regular smoker? ☐ Yes ☐ No ☐ Unknown

ⓘ Secondhand smoke causes health problems in infants and children, such as asthma attacks, lung infections, ear infections, and sudden infant death syndrome (SIDS).

Does your child have more difficulty than a typical child of their age doing regular activities such as going to the bathroom, eating, walking, or bathing by themselves? (Answer only if age 4 years or older.) ☐ Yes ☐ No ☐ Unknown

If yes, who helps with these activities now? _____

If yes, could you use more help with these activities? ☐ Yes ☐ No ☐ Unknown

SOCIAL CONCERNS

Within the past 12 months, did you worry that your food would run out before you got money to buy more?
☐ Yes ☐ No ☐ Unknown

Within the past 12 months, did the food you bought just not last, and you didn't have money to get more?
☐ Yes ☐ No ☐ Unknown

In the past 2 months, have you been living in stable housing that you own, rent, or stay in as part of a household?
☐ Yes ☐ No ☐ Unknown

Do you currently have concerns about having enough money to pay for your basic needs?
☐ Yes ☐ No ☐ Unknown

If yes, please explain: _____

Do you always feel safe in your home and around all the people in your life?
☐ Yes ☐ No ☐ Unknown

If no, please explain: _____

Do you know of any very scary or upsetting things that happened to you, your child, or anyone in your family?
☐ Yes ☐ No ☐ Unknown

If yes, please explain: _____

Do you have access to a safe, reliable telephone? ☐ Yes ☐ No ☐ Unknown

Do you ever have any problems with transportation to your medical appointments?
☐ Yes ☐ No ☐ Unknown

PHYSICAL HEALTH

Have you ever been told by a doctor or provider that your child has any of these conditions?

☐ Yes, please check all below that apply ☐ No ☐ Unknown

☐ Bone/growth disorder
☐ Transplant
☐ Developmental delay
☐ Cancer
☐ Kidney disease
☐ Eczema
☐ Sickle Cell disease (not trait)
☐ Premature birth
☐ Cystic Fibrosis
☐ Heart disease
☐ Seizures
☐ Asthma
☐ Diabetes, Type 2
☐ Elevated blood lead level
☐ Stroke
☐ Pre-diabetes
☐ Diabetes, Type 1

If yes to transplant, how long ago was the transplant?

☐ More than 1 year ☐ In the last 12 months ☐ On the transplant list ☐ Unknown

Does your child have any other conditions not listed above? ☐ Yes ☐ No

☐ If yes, please explain: _____

Has your child's condition affected their ability to do regular daily activities or go to school in the past 7 days? Use a 0 to 10 rating scale to answer the question. 0 = no effect and 10 = strong effect.

☐ 0	☐ 1-3	☐ 4-6	☐ 7-10	☐ Unknown
Condition had no effect on daily activities	Condition had a little effect on daily activities	Condition had more effect on daily activities	Condition prevented them from daily activities	

BEHAVIORAL HEALTH

Have you ever been told by a doctor or provider that your child has any of these behavioral health conditions?

☐ Yes, please check all the below that apply. ☐ No ☐ Unknown

☐ ADD/ADHD
☐ Eating disorder
☐ Autism
☐ Learning disability
☐ Depression

Does your child have any other conditions not listed above? ☐ Yes ☐ No

☐ If yes, please explain: _____

Has your child received treatment for a behavioral health condition or substance misuse in the past 6 months?

☐ Yes ☐ No ☐ Unknown

If yes, what type of treatment? _____

In the last 3 months, has your child been to the emergency room (ER) or hospitalized due to a behavioral health condition? ☐ Yes ☐ No ☐ Unknown

Would you like help getting treatment for your child for a behavioral health disorder?
☐ Yes ☐ No ☐ Unknown

Do you have any concerns about your child's learning, behavior, or development?
☐ Yes ☐ No ☐ Unknown

If yes, what concerns? _____

Is your child 12 years or older? ☐ Yes ☐ No ☐ Unknown

If yes, please answer the following:

In the past 2 weeks, how often has your child had problems with sleeping, such as trouble falling asleep, staying asleep, or waking up too early?
☐ Not at all ☐ Rare ☐ Less than a day or two ☐ Several days
☐ More than half the days ☐ Nearly every day ☐ Unknown

In the past 2 weeks, how often has your child had less fun doing things that they used to?
☐ Not at all ☐ Rare ☐ Less than a day or two ☐ Several days
☐ More than half the days ☐ Nearly every day ☐ Unknown

In the past 2 weeks, how often has your child seemed sad or depressed for several hours?
☐ Not at all ☐ Rare ☐ Less than a day or two ☐ Several days
☐ More than half the days ☐ Nearly every day ☐ Unknown

In the past 2 weeks, has your child smoked a cigarette, cigar, pipe, e-cigarette, vaped, or used snuff/chewing tobacco?
☐ Yes ☐ No ☐ Unknown

In the past 2 weeks, has your child had an alcoholic beverage (beer, wine, liquor)?
☐ Yes ☐ No ☐ Unknown

In the past 2 weeks, has your child used drugs like marijuana, cocaine, crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants, solvents (like glue), or methamphetamine (like speed)?
☐ Yes ☐ No ☐ Unknown

In the past 2 weeks, has your child used any medicine without a doctor's prescription, such as painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or steroids?
☐ Yes ☐ No ☐ Unknown

GENERAL INFORMATION

Assessment completed by: _____ Date: _____

Relationship to member: ☐ Self ☐ Parent or guardian ☐ Member representative with permission

☐ Vendor ☐ Health plan representative ☐ Other (explain) _____

Please be sure you answered all the questions. Thank you for your time. We will be in touch with you.