

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

i 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

i 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

i 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

i 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

i 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

i 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

i 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

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

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.

- | | | | | |
|---|---|---|--|----------------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 1-3 | <input type="checkbox"/> 4-6 | <input type="checkbox"/> 7-10 | <input type="checkbox"/> 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

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Autism | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Learning disability | |

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 check to make sure you answered all the questions.
We will call you after we receive your completed survey. Thank you.**