Health Risk Screening (Age Birth – 6 months)

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

network health

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: _____

BIRTH HISTORY

Was your child born by vaginal delivery or C-section?

☐ Vaginal delivery ☐ C-section delivery ☐ Unknown

Was your child born prior to 39 weeks gestation?

☐ Yes ☐ No ☐ Unknown

If yes, what week was your child born (between 22-38 weeks)? _____

In this pregnancy, were there any problems?

☐ Yes ☐ No ☐ Unknown

If yes, what problem(s) occurred? _____

In this pregnancy, did labor start on its own?

☐ Yes ☐ No ☐ Unknown

If no, why was the delivery induced? _____

☐ Diabetes ☐ Baby was not growing enough ☐ Premature rupture of membranes ☐ Placental abruption (separation) ☐ Preeclampsia/ high blood pressure

☐ Non-medical reason ☐ Scheduled C-section ☐ Unknown ☐ Other

If other, why were you induced? _____

What did your child weight a birth? _____ pounds _____ ounces

Did your child have to spend any extra time in the hospital after birth?

☐ Yes ☐ No ☐ Unknown

If yes, how much time? ☐ Less than one week ☐ 2 weeks ☐ 3 weeks

☐ 4 weeks ☐ 5 weeks ☐ 6 weeks ☐ More than 6 weeks ☐ Unknown

What was your child fed in the hospital after birth?

☐ Breast milk ☐ Breast milk and formula ☐ Formula ☐ Unknown

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 ready for 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

ⓘ It is important to find a doctor or provider to help your child stay healthy and in case they get sick.

Has your child seen their doctor or provider since birth? ☐ Yes ☐ No ☐ Unknown

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

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

ⓘ Children get most of their vaccines during the first 2 years of life. That's because the diseases these vaccines prevent are very harmful to young children.

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

What is your child's current weight? _____ pounds

Have you or a doctor or provider been concerned about your child's weight?
☐ Yes, overweight ☐ Yes, underweight ☐ No ☐ Unknown

What is your child eating now?
☐ Breast milk ☐ Breast milk and formula ☐ Formula ☐ Unknown

Does your child always sit in a car seat when riding 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 baby have a safe place to sleep?
☐ Yes ☐ No ☐ Unknown

ⓘ Babies can sleep in parents' room but not in the same bed. Babies at this age should sleep on their back. The bed should be firm and not contain any soft bedding or toys.

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).

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	☐ Sickle Cell disease (not trait)	☐ Heart disease
☐ Transplant	☐ Premature birth	☐ Eczema
☐ Developmental delay	☐ Cystic Fibrosis	☐ Seizures
☐ Cancer	☐ Kidney disease	

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

If yes, please explain: _____

BEHAVIORAL HEALTH

Over the past 2 weeks, have you felt down, depressed, or hopeless?

☐ Yes ☐ No ☐ Unknown

Over the past 2 weeks, have you felt little interest or pleasure in doing things?

☐ Yes ☐ No ☐ Unknown

Do you have any concerns about your child's learning, behavior, or development?

☐ Yes ☐ No ☐ Unknown

If yes, what are your concerns? _____

_____

GENERAL INFORMATION

Assessment completed by: _____ Date: _____

Relationship to member: ☐ 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.