1080 Jordan Creek Parkway
Suite 100 South
West Des Moines, IA 50266

Health Risk Screening – Child (Age 6 Months – 17 Years)

Member Information:

1) Preferred Mailing Address: _____
2) Preferred Phone Number: +_ (___) ___ - ____
3) Email Address: _____
4) Race (Check Whichever Applies):

- ☐ American Indian / Alaska Native
- ☐ Black / African American
- ☐ White
- ☐ I prefer not to answer
- ☐ Asian
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ Other
- ☐ Unknown

a. If you chose other, list race here: _____

b. **If you chose Native American:** Is your child eligible to receive Indian Health Services?

☐ Yes ☐ No

5) Ethnicity:

- ☐ Hispanic or Latino
- ☐ I prefer not to answer
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Other

a. If you chose other, list ethnicity here: _____

6) Language:

- ☐ English
- ☐ Other
- ☐ Spanish
- ☐ Unknown

a. If you chose other, list preferred language here: _____

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7) Does your child have any problems with your hearing, vision, or speech requiring special services?

☐ Yes ☐ No ☐ Unknown

a. If yes, explain: _____

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Global Health / Safety

8) In general, how would you rate your child's health?

☐ Excellent ☐ Very Good ☐ Good
☐ Fair ☐ Poor ☐ Unknown

a. If you chose poor, please explain: _____

_____

9) On a scale of 0 – 10, how ready are you to make changes for your child's health? _____

a. If you wrote 8, 9, or 10, tell us which changes you'd like to make: _____

_____

10) Does your child have a health care provider?

☐ Yes ☐ No* ☐ Unknown

It is important to identify a doctor or health care provider to help you stay healthy and in case you get sick

a. If you answered yes, what is your child's health care provider's name?

_____

b. Has your child seen their doctor or health care provider in the last 12 months?

☐ Yes ☐ No ☐ Unknown

i. If you answered yes, what did they see their doctor for?

☐ Preventative Care ☐ Sick Care ☐ Post Hospital Visit
☐ Post Emergency Room Visit ☐ Other Visit

ii. If you chose Other Visit, what was the visit for? _____

11) Has your child been to all their recommended visits in the last year? (At least yearly or more if the child is under 3 years old).

☐ Yes ☐ No ☐ Unknown

12) How old is your child? _____

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13) If your child is ages **6 months – 3 years old**:

a. Has your child had at least one lead screening before the age of 2?

☐ Yes ☐ No ☐ Unknown

b. Are your child's immunizations up to date?

☐ Yes ☐ No ☐ Unknown

c. 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 you and your family from the flu

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

☐ None ☐ One Time

☐ Two Times ☐ Three or More Times

e. How many times has your child been in the Emergency Department in the last 3 months?

☐	None	☐	One Time
☐	Two Times	☐	Three or More Times

f. How many medicines is your child currently taking that were prescribed by their doctor or health care provider? _____

i. If your child is taking prescriptions, is there anything that prevents them from taking the medicine the way their doctor or health care provider wants them to?

☐ Yes ☐ No ☐ Unknown

1. If Yes, please explain what prevents your child from taking their medicine: _____

ii. Do you ever forget to give your child their medicine?

☐ Yes ☐ No ☐ Unknown

g. 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

h. Does your child live with anyone who is a regular smoker?

☐ Yes ☐ No ☐ Unknown

14) If your child is ages **4 years – 10 years:**

a. Has your child had at least one lead screening before the age of 2?

☐ Yes ☐ No ☐ Unknown

b. Are your child's immunizations up to date?

☐ Yes ☐ No ☐ Unknown

c. 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 you and your family from the flu

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

☐	None	☐	One Time
☐	Two Times	☐	Three or More Times

e. How many times has your child been in the Emergency Department in the last 3 months?

☐	None	☐	One Time
☐	Two Times	☐	Three or More Times

f. How many medicines is your child currently taking that were prescribed by their doctor or health care provider? _____

i. If your child is taking prescriptions, is there anything that prevents them from taking the medicine the way their doctor or health care provider wants them to?

☐ Yes ☐ No ☐ Unknown

1. If Yes, please explain what prevents your child from taking their medicine: _____

ii. Do you ever forget to give your child their medicine?

☐ Yes ☐ No ☐ Unknown

g. When was the last time your child saw a dentist?

☐	In the last 6 months	☐	In the last 12 months	☐	More than 1 year ago*
☐	Have never seen one	☐	Unknown		

Routine dental care is important for your child's oral and physical health

h. What is your child's height? (Enter in feet / inches) _____ ft. _____ in.

i. What is your child's weight? (Enter in pounds) _____ lbs.

j. Have you or your health care provider been concerned about your child's weight?

☐	Yes (overweight)	☐	Yes (underweight)	☐	No

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i. If your child is overweight, are you interested in working toward a healthier weight for your child?

☐ Yes ☐ No ☐ Unknown

k. Does your child eat a healthy diet, such as eating fruits, vegetables, and whole grains, every day and limiting their sugar and saturated fats?

☐	Yes, most of the time	☐	Yes, sometimes
☐	No, not very often	☐	Unknown

l. Does your child participate in regular physical activity?

☐	Yes	☐	No
☐	Child unable to exercise due to medical condition	☐	Unknown

m. 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

n. Does your child always wear a helmet when riding a bike, scooter, etc.?

☐ Yes ☐ No ☐ Unknown

o. Does your child live with anyone who is a regular smoker?

☐ Yes ☐ No ☐ Unknown

p. 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?

☐ Yes ☐ No ☐ Unknown

i. If you answered yes, who helps your child with these activities now?

_____

ii. Could you use additional help with these activities?

☐ Yes ☐ No ☐ Unknown

15) If your child is female and age 11 - 15, or male and age 11 – 17:

a. Are your child's immunizations up to date?

☐ Yes ☐ No ☐ Unknown

b. Has your child had the following vaccines?

i. Meningococcal (Meningitis Vaccine):

☐ Yes ☐ No ☐ Unknown

ii. Tetanus shot since they turned 10:

☐ Yes ☐ No ☐ Unknown

iii. HPV (cancer prevention) vaccine series:

☐	1 Dose	☐	2 Doses
☐	No Doses	☐	Unknown

iv. Flu shot in the last 12 months:

☐ Yes ☐ No ☐ Unknown

c. How many times has your child been to the hospital in the last three months?

☐	None	☐	One Time
☐	Two Times	☐	Three or More Times

d. How many times has your child been in the Emergency Department in the last 3 months?

☐	None	☐	One Time
☐	Two Times	☐	Three or More Times

e. How many medicines is your child currently taking that were prescribed by their doctor or health care provider? _____

i. If your child is taking any prescriptions, does anything prevent them from taking their medicine the way their doctor or health care provider wants them to?

☐ Yes ☐ No ☐ Unknown

1. If yes, what prevents your child from taking their medicines?

_____

2. Do you ever forget to give your child their medicines?

☐ Yes ☐ No ☐ Unknown

f. When was the last time your child saw a dentist?

☐	In the last 6 months	☐	In the last 12 months	☐	More than 1 year ago*
☐	Have never seen one	☐	Unknown		

g. What is your child's height? (Enter in feet / inches) _____ ft. _____ in.

h. What is your child's weight? (Enter in pounds) _____ lbs.

i. Have you or your health care provider been concerned about your child's weight?

☐	Yes (overweight)	☐	Yes (underweight)	☐	No

i. If your child is overweight, are you interested in working toward a healthier weight for your child?

☐ Yes ☐ No ☐ Unknown

j. Does your child eat a healthy diet, such as eating fruits, vegetables, and whole grains, every day and limiting their sugar and saturated fats?

☐	Yes, most of the time	☐	Yes, sometimes
☐	No, not very often	☐	Unknown

k. Does your child participate in regular physical activity?

☐	Yes	☐	No
☐	Child unable to exercise due to medical condition	☐	Unknown

l. 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

m. Does your child always wear a helmet when riding a bike, scooter, etc.?

☐ Yes ☐ No ☐ Unknown

n. Does your child live with anyone who is a regular smoker?

☐ Yes ☐ No ☐ Unknown

o. 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?

☐ Yes ☐ No ☐ Unknown

i. If you answered yes, who helps your child with these activities now?

_____

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ii. Could you use additional help with these activities?

☐ Yes ☐ No ☐ Unknown

16) If your child is female age 16 – 17 years old:

a. Are your child's immunizations up to date?

☐ Yes ☐ No ☐ Unknown

b. Has your child had the following vaccines?

i. Meningococcal (Meningitis Vaccine):

☐ Yes ☐ No ☐ Unknown

ii. Tetanus shot since they turned 10:

☐ Yes ☐ No ☐ Unknown

iii. HPV (cancer prevention) vaccine series:

☐	1 Dose	☐	2 Doses
☐	No Doses	☐	Unknown

iv. Flu shot in the last 12 months:

☐ Yes ☐ No ☐ Unknown

c. How many times has your child been to the hospital in the last three months?

☐	None	☐	One Time
☐	Two Times	☐	Three or More Times

d. How many times has your child been in the Emergency Department in the last 3 months?

☐	None	☐	One Time
☐	Two Times	☐	Three or More Times

e. How many medicines is your child currently taking that were prescribed by their doctor or health care provider? _____

i. If your child is taking any prescriptions, does anything prevent them from taking their medicine the way their doctor or health care provider wants them to?

☐ Yes ☐ No ☐ Unknown

1. If yes, what prevents your child from taking their medicines?

_____

2. Do you ever forget to give your child their medicines?

☐ Yes ☐ No ☐ Unknown

f. When was the last time your child saw a dentist?

☐	In the last 6 months	☐	In the last 12 months	☐	More than 1 year ago*
☐	Have never seen one	☐	Unknown		

g. What is your child's height? (Enter in feet / inches) _____ ft. _____ in.

h. What is your child's weight? (Enter in pounds) _____ lbs.

i. Have you or your health care provider been concerned about your child's weight?

☐	Yes (overweight)	☐	Yes (underweight)	☐	No

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i. If your child is overweight, are you interested in working toward a healthier weight for your child?

☐ Yes ☐ No ☐ Unknown

j. Does your child eat a healthy diet, such as eating fruits, vegetables, and whole grains, every day and limiting their sugar and saturated fats?

☐	Yes, most of the time	☐	Yes, sometimes
☐	No, not very often	☐	Unknown

k. Does your child participate in regular physical activity?

☐	Yes	☐	No
☐	Child unable to exercise due to medical condition	☐	Unknown

l. 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

m. Does your child live with anyone who is a regular smoker?

☐ Yes ☐ No ☐ Unknown

n. Do you suspect that your child may be sexually active now or has been in the past?

☐ Yes ☐ No ☐ Unknown

o. Has your child been tested in the last year for STI's like Chlamydia?

☐ Yes ☐ No ☐ Unknown

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i. If yes, where and when did your child have the Chlamydia testing completed?

☐ Yes ☐ No ☐ Unknown

p. Is your child pregnant?

☐ Yes ☐ No ☐ Unknown

i. If yes, when is the due date? ____/____/____

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Social Concerns:

17) In the last 12 months, did you worry your food would run out before you got money to buy more?

☐ Yes ☐ No ☐ Unknown

18) In the last 12 months, did the food you bought just not last and you didn't have money to get more?

☐ Yes ☐ No ☐ Unknown

19) 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

20) Do you currently have concerns about having enough money to pay for your basic needs?

☐ Yes ☐ No ☐ Unknown

a. If yes, please explain these concerns: _____

_____

_____

21) Do you feel safe in your home and around all the people in your life?

☐ Yes ☐ No ☐ Unknown

a. If no, please explain any safety concerns you have: _____

_____

_____

22) Do you know of any really scary or upsetting things that have happened to you, your child, or anyone in your family?

☐ Yes ☐ No ☐ Unknown

a. If yes, please explain: _____

_____

_____

23) Do you have access to a safe, reliable telephone?

☐ Yes ☐ No ☐ Unknown

24) Do you ever have any problems with transportation to your medical appointments?

☐ Yes ☐ No ☐ Unknown

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Physical Health:

25) Has a healthcare provider ever told you that your child has one or more of these conditions?

(Check all that apply)

	Asthma		Bone / Growth Disorder		Cancer
	Cystic Fibrosis		Developmental Delay		Diabetes, Type 1
	Diabetes, Type 2		Pre-Diabetes		Eczema
	Elevated Blood Lead Levels		Heart Disease		Kidney Disease
	Premature Birth		Seizures		Sickle Cell Disease
	Stroke		Transplant		

Do you have any other conditions not listed above? List them here: _____

_____

a. If your child has had a **TRANSPLANT:** How long ago was the transplant? _____

26) On a scale of 0 – 10, how much did your child's health problems have an effect on their daily activities or schooling during that past 7 days? (0 = Health problems had no effect, 10 = Health problems prevented me from daily activity) _____

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Behavioral Health:

27) Have you ever been told by a health care provider that your child has any of the following behavioral health conditions?

☐	ADD / ADHD	☐	Autism
☐	Eating Disorder	☐	Learning Disability

Does your child have any other behavioral health disorder not listed above? _____

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

☐ Yes ☐ No ☐ Unknown

a. If yes, what type of treatment? _____

29) Has your child been to the ER or hospitalized in the last 3 months due to a behavioral health condition?

☐ Yes ☐ No ☐ Unknown

30) Would you like help getting treatment for your child for a behavioral health disorder?

☐ Yes ☐ No ☐ Unknown

31) Do you have any concerns about your child's development?

☐ Yes ☐ No ☐ Unknown

a. If yes, what are your concerns? _____

_____

32) Is your child age 12 or over?

☐ Yes ☐ No ☐ Unknown

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a. If Yes:

b. In the past 2 weeks, how often has your child had problems with sleeping (trouble falling asleep, staying asleep, or waking up too early)?

	Never		Less than a day or 2		Several Days
	More than half the days		Nearly Every Day		Unknown

c. In the past 2 weeks, how much has your child had less fun doing things than he / she used to?

	Never		Less than a day or 2		Several Days
	More than half the days		Nearly Every Day		Unknown

d. In the past 2 weeks, how often has your child seemed sad or depressed for several hours?

	Never		Less than a day or 2		Several Days
	More than half the days		Nearly Every Day		Unknown

e. In the past 2 weeks, has your child had an alcoholic beverage (beer, wine, liquor)?

☐ Yes ☐ No ☐ Unknown

f. In the past 2 weeks, has your child smoked a cigarette, a cigar, a pipe, or used snuff or chewing tobacco?

☐ Yes ☐ No ☐ Unknown

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g. In the past 2 weeks, has your child used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogenics (like LSD), heroin, inhalants, or solvents (like glue) or methamphetamine (like speed)?

☐ Yes ☐ No ☐ Unknown

h. 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 steroids?

☐ Yes ☐ No ☐ Unknown

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Supplemental Assessment:

33) How many family members, including yourself, do you currently work with? _____

34) What is your housing situation?

- ☐ I have housing and I am NOT worried about losing it in the next 6 months
- ☐ I have housing but I AM worried about losing housing in the next 6 months
- ☐ I do not have housing today but:

a. If you chose "I do not have housing today but:", answer the following question.

i. I am:

- ☐ Staying with others
- ☐ Staying in a shelter
- ☐ Staying in a hotel
- ☐ Living outside or in a car

35) How difficult is it for you to understand information that doctors, nurses, and other health professionals tell you?

- ☐ Very Easy
- ☐ Somewhat Difficult
- ☐ Somewhat Easy
- ☐ Very Difficult

36) What is your current work situation?

- ☐ Unemployed
- ☐ Full-Time Work
- ☐ Part-Time or Temporary Work
- ☐ Otherwise unemployed but not seeking work

37) In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply:

- ☐ Food
- ☐ Mental Health Care
- ☐ Child Care
- ☐ Transportation
- ☐ Clothing
- ☐ Utilities
- ☐ Phone
- ☐ Dental Care
- ☐ Eye-Care
- ☐ Medical Care

38) If you have trouble getting transportation when you need it, what is the MAIN reason you cannot get to where you want to go?

- ☐ I do not have trouble getting transportation
- ☐ Person who usually takes me is unavailable
- ☐ I do not have a personal vehicle
- ☐ Car broke down
- ☐ Costs too much
- ☐ Transit system unavailable

39) Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their mind is troubled. How stressed are you?

- ☐ Not at all
- ☐ A little bit
- ☐ Very much
- ☐ Somewhat
- ☐ Quite a bit

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40) How often do you feel unsafe in your neighborhood?

- ☐ Never
- ☐ Sometimes
- ☐ Frequently
- ☐ Rarely
- ☐ Fairly often

41) In the past year, have you been afraid of your partner or ex-partner?

- ☐ Yes
- ☐ Unsure
- ☐ No
- ☐ I haven't had a partner in the last year

42) Notes: _____

_____

_____

43) During the past 12 months, have you had a dental problem that you would have liked to see a dentist about but you did NOT see a dentist?

- ☐ Yes
- ☐ No

a. If yes, what is the main reason you have not visited the dentist in the last 12 months?

- ☐ Fear, apprehension, pain
- ☐ Do not have/know a dentist
- ☐ Cannot get to the office / no appointment available
- ☐ Cost
- ☐ Did not have the time
- ☐ Other priorities

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44) In the past 12 months, have you gone to a hospital emergency room for a dental problem?

☐ Yes ☐ No

a. If yes, check which of the following reasons you went to the hospital emergency room:

☐ Dental Pain/Infection ☐ Dental Trauma/Accident

☐ Other

i. If you chose other, please explain: _____
_____

45) On a scale of 1 – 10, how strongly do you agree with the following statement?

"I can manage and control health problems."

_____ (10 is very strong, 1 is not strong at all)

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General Information:

46) Date of Assessment: ____/____/____

47) Assessment Completed By (Your Name Here) _____

48) Relationship to member: _____

(Self, Parent / Guardian, Envolve, Health Plan, Vendor, Etc.)

49) Enroll Member in Program now?

☐ Yes ☐ No

50) Member / Guardian agrees to participate in program?

☐ Yes ☐ No ☐ N/A