

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 Asian	
Black / African American Native Ha	awaiian / Other Pacific Islander
White Other	
I prefer not to answer Unknown	I
 a. If you chose other, list race here: b. If you chose Native American: Is your child eligible Services? Yes No 	
5) Ethnicity:	
Hispanic or Latino Not Hispanic or Latino I prefer not to answer Unknown	Other
a. If you chose other, list ethnicity here:	
6) Language:	
English Spanish	
Other Unknown	
a. If you chose other, list preferred language here:	



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

	Ye	es	No		Unknown	
а	If yes, explain: _			L	1	



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?



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

Three or More Times Two Times

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

months?

d

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? _____

No

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

Yes

- 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?

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



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

weight for your child?

Yes

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?

No

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

I. 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?

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

- 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?

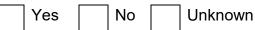
Yes No Unknown

No

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



ii. Could you use additional help with these activities?



- 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):

Y	es	No		Unknown
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ii. Tetanus shot since they turned 10:

Yes No Unknown

iii. HPV (cancer prevention) vaccine series:

1 Dose	2 Doses
No Doses	Unknown

No

iv. Flu shot in the last 12 months:

Y	es

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?

Unknown

Yes	No	

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

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?

No

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

Does your child always use a seat belt or sit in a car seat when you drive or ride in a Ι.

car?

	Yes		No		Unknown
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m. Does your child always wear a helmet when riding a bike, scooter, etc.?

ſes	No	U

No

No	Unknown
••	••••••

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

	Yes

Unknown

o. Does your child have more difficulty than a typical child of their age doing regular

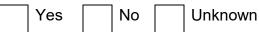
activities such as going to the bathroom, eating, walking, or bathing by themselves?

No Unknown Yes

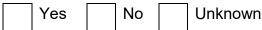
i. If you answered yes, who helps your child with these activities now?



ii. Could you use additional help with these activities?



- 16) If your child is female age 16 17 years old:
 - a. Are your child's immunizations up to date?



- 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

No

iv. Flu shot in the last 12 months:

Yes

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?

Unknown

Yes	No	

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

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?

No

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

I. Does your child always use a seat belt or sit in a car seat when you drive or ride in a

car?

`	Yes		
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Unknown

Unknown

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

No

Yes	No	
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n. Do you suspect that your child may be sexually active now or has been in the past?

Yes No	Unknown
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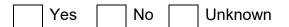
o. Has your child been tested in the last year for STI's like Chlamydia?

Yes No Unknown

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



p. Is your child pregnant?

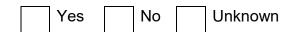
	Yes		No		Unknown
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i. If yes, when is the due date? ___/__/



Social Concerns:

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



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



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

Yes No Unknow	vn
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a. If yes, please explain these concerns: _____

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

No

Yes	

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 yo	ou have access to a safe, reliable telephone?
	Yes No Unknown
24) Do yo	u ever have any problems with transportation to your medical appointments?
	Yes No Unknown



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	Heart Disease	Kidney
Levels		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)



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
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- 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



- 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

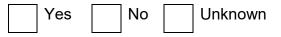
c. In the past 2 weeks, how much has your child had less fun doing things than he / she used to?

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

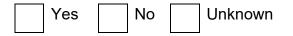
d. In the past 2 weeks, how often has your child seemed sad or depressed for several hours?

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)?

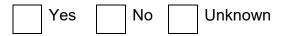


f. In the past 2 weeks, has your child smoked a cigarette, a cigar, a pipe, or used snuff or chewing tobacco?





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)?



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



Supplemental Assessment:

- 33) How many family members, including yourself, do you currently live with?
- 34) What is your housing situation?

I have housing and I am NOT worried about losing it in the next 6 months

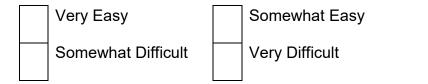
I have housing but I AM worried about losing housing in the next 6 months

I do not have housing today but:

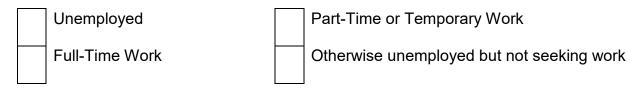
- a. If you chose "I do not have housing today but:", answer the following question.
- i. I am: Staying with others Staying in a shelter Staying in a shelter Living outside or in a car

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

professionals tell you?

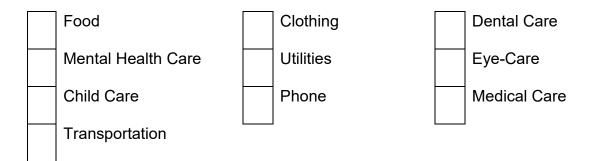


36) What is your current work situation?



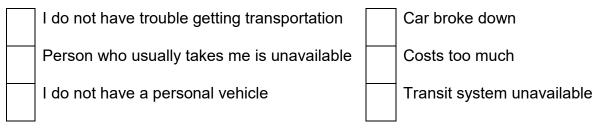


37) In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply:



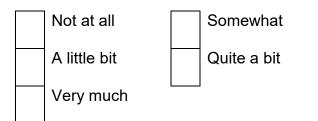
38) If you have trouble getting transportation when you need it, what is the MAIN reason you

cannot get to where you want to go?



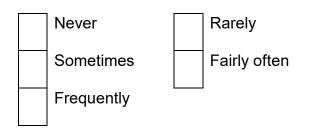
39) Stress is when someone feels tense, nervous, anxious, or can't sleep at night because their

mind is troubled. How stressed are you?





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



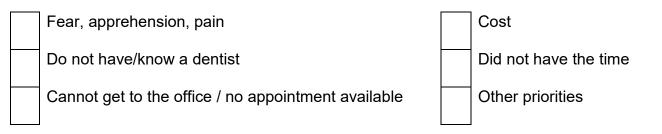
41) In the past year, have you been afraid of your partner or ex-partner?

Yes	No
Unsure	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?





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



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)



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	3	No
Yes	5	INO

50) Member / Guardian agrees to participate in program?

