Health Risk Screening: Child (Ages 6 Months–17 Years)

Member Information

1. Preferred mailing address: _____
2. Preferred phone number: +__ (_____) _____-_____
3. Email address: _____
4. Race:

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

Please list other race: _____

Is your child Native American?

☐ Yes ☐ No ☐ I prefer not to answer ☐ Unknown

Is your child eligible to receive Indian Health Services?

☐ Yes ☐ No ☐ I prefer not to answer ☐ Unknown

5. Ethnicity:

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

Please list other ethnicity: _____

6. Preferred Language:

☐ English ☐ Spanish ☐ Other ☐ Unknown

Please list other preferred language: _____

7. What is your child's gender identity?

☐ Female
☐ Male
☐ Non-Binary (Doesn't identify as either)
☐ Transgender
☐ I prefer not to answer
☐ Unknown

8. Does your child have any problems with their hearing, vision, or speech requiring special services?

☐ Yes ☐ No ☐ I prefer not to answer ☐ Unknown

Please explain problems with hearing, vision, or speech: _____

9. Do you need interpretation services?
☐ Yes ☐ No ☐ I prefer not to answer ☐ Unknown

10. In what language do you prefer written materials?
☐ English ☐ Spanish ☐ I prefer not to answer ☐ Other

Please list other language for written materials: _____

11. How difficult is it for you to understand information that doctors, nurses, and other health professionals tell you? Would you say it is:
☐ Very easy ☐ Somewhat easy ☐ Somewhat difficult ☐ Very difficult

12. What are your child's preferred pronouns?
☐ He/Him ☐ She/Her ☐ They/Them ☐ I prefer not to answer ☐ Other

If other, please specify: _____

13. What gender was your child assigned at birth on their birth certificate?
☐ Female ☐ Male ☐ I prefer not to answer ☐ Unknown

14. Sexual Orientation: Which of the following best describes your child? (Emotional, romantic or sexual attraction)
☐ Bisexual ☐ Straight or heterosexual ☐ Lesbian, gay, or homosexual ☐ Not sure
☐ I prefer not to answer ☐ Other

If Other, please specify: _____

15. How many family members, including yourself, do you currently live with?

_____

Global Health / Safety

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

If you chose Poor, please explain the reason for your child's poor health rating: _____

_____

17. On a scale of 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 wrote 8–10, what changes are you ready to make for your child's health? _____

_____

18. Does your child have a doctor or health care provider?

☐ Yes ☐ No ☐ Unknown

19. It is important to identify a doctor or health care provider to help your child stay healthy and in case they get sick. **Would you like help finding a doctor or health care provider?**

☐ Yes ☐ No

20. What is your child's doctor or health care provider's name?

_____

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

☐ Yes ☐ No ☐ Unknown

What did your child see their doctor or health care provider for in the past 12 months?

☐ Preventative care ☐ Sick care ☐ Post-hospital visit
☐ Post-emergency room visit ☐ Other visit

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

22. Has your child gone to all their recommended visits in the last year? (At least yearly or more if the child is under age three.)

☐ Yes ☐ No ☐ Unknown

23. Regular wellness exams can help make sure your child stays as healthy as they can. **Would you like help making an appointment?**

☐ Yes ☐ No ☐ Unknown

24. Age of child?

☐ 6 months – 3 years old ☐ 4-10 years old ☐ Female 11-15 years old
☐ Female 16-17 years old ☐ Male 11-17 years old ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

27. Has your child had the following vaccines?

Meningococcal (meningitis vaccine)

☐ Yes ☐ No ☐ Unknown

Tetanus shot since they turned 10

☐ 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

28. 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.*

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

☐ Yes ☐ No ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

Where and when did your child have the Chlamydia testing completed?

_____

31. Is your child pregnant?

☐ Yes ☐ No ☐ Unknown

What is your child's due date?

_____

32. 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

33. 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 ☐ Unknown

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

☐ 0 prescriptions ☐ 1-3 prescriptions ☐ 4-7 prescriptions
☐ Greater than or equal to 8 prescriptions ☐ Unknown

35. Does anything prevent your child from taking their medicines the way their doctor or health care provider wants them to?

☐ Yes ☐ No ☐ Unknown

36. What prevents your child from taking their medicines?

_____

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

☐ Yes ☐ No ☐ Sometimes ☐ Unknown

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

☐ In the last 6 months ☐ In the last 12 months ☐ More than 12 months ago

Great job! Keep it up!

☐ Have never seen one ☐ Unknown

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

39. What is your child's height? (enter in feet/inches)

Feet	Inches
☐ 2	☐ 0
☐ 3	☐ 1
☐ 4	☐ 2
☐ 5	☐ 3
☐ 6	☐ 4
☐ 7	☐ 5
☐ Unknown	☐ 6
	☐ 7
	☐ 8
	☐ 9
	☐ 10
	☐ 11
	☐ Unknown

40. What is your child's weight? (enter response in pounds)_____lbs.

41. Have you or your health care provider been concerned about your child's weight?
☐ Yes - Overweight ☐ Yes - Underweight ☐ No ☐ Unknown

42. Are you interested in working toward a healthier weight for your child?
☐ Yes ☐ No ☐ Unknown

43. 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

44. Does your child participate in regular physical activity?
☐ Yes ☐ No ☐ Child unable to exercise due to medical conditions ☐ Unknown
Regular physical activity helps improve overall health and fitness, and reduces the risk for many chronic diseases. Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

45. 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 most effective ways to save lives and reduce injuries in crashes.

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

☐ Yes ☐ No ☐ Unknown

Wearing a helmet is one of the most effective ways to reduce head injuries.

47. 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

Who helps your child with these activities now?

_____

Could you use additional help with these activities?

☐ Yes ☐ No ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

Secondhand smoke causes numerous health problems in infants and children, including more asthma attacks, respiratory infections, ear infections, and sudden infant death syndrome (SIDS).

49. How often do you feel unsafe in your neighborhood?

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly Often ☐ Frequently

50. In the past year have you been afraid of your partner or ex-partner?

☐ Yes ☐ No ☐ Unknown ☐ I have not had a partner in the past year

Notes: _____

51. Which of the following types of equipment do you use that require electricity? (check all that apply)

☐ Wheelchair ☐ CPAP/BIPAP ☐ Refrigerated medications ☐ Ventilator

☐ Oxygen ☐ None ☐ Other

Please list other equipment that requires electricity:

_____

52. Are you on dialysis?

☐ Yes ☐ No ☐ Choose not to answer

53. Are you considered homebound? (Homebound means that leaving your home takes considerable and taxing effort)

☐ Yes ☐ No ☐ Choose not to answer

Social Concerns

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

☐ Yes ☐ No ☐ Unknown

If yes, please explain your concerns about money to pay for basic needs: _____

_____

_____

55. Do you feel safe in your daily life?

☐ Yes ☐ No ☐ Unknown

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

_____

_____

56. 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

If yes, please explain: _____

_____

_____

57. Do you have access to a safe, reliable telephone?

☐ Yes ☐ No ☐ Unknown

58. 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 ☐ Clothing ☐ Dental care ☐ Mental health care ☐ Utilities
☐ Child care ☐ Phone ☐ Medical care ☐ Transportation ☐ Eye care

59. In the past 12 months, has the electric, gas, oil, or water company threatened to shut off services in your home?

☐ Yes ☐ No ☐ Already shut off

60. Currently, are you or any family members you live with unable to get any of the following when it was really needed? (Check all that apply)

☐ Food ☐ Clothing ☐ Dental care ☐ Mental health care ☐ Utilities
☐ Child care ☐ Phone ☐ Medical care ☐ Transportation ☐ Eye care

61. In the past 12 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?

☐ Yes ☐ No ☐ Unknown

62. 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 not available

63. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

☐ Yes ☐ No ☐ Unknown

64. What is your housing situation today?

☐ I have housing today and I am NOT worried about losing housing in the next 6 months
☐ I have housing today but I AM worried about losing housing in the next 6 months
☐ I do not have housing today, BUT I am:
  ☐ Staying with others
  ☐ Staying in a hotel
  ☐ Staying in a shelter
  ☐ Living outside on the street, on a beach, in a car, or in a park

65. What is your housing situation today?

☐ I have housing
☐ I do not have housing (staying with others, hotel, shelter, living outside, car, or park)
☐ I choose not to answer this question

66. What is your current work situation?

☐ Unemployed
☐ Part-time or temporary work
☐ Full-time work
☐ Otherwise unemployed but not seeking work (ex. student, retired, disabled, unpaid primary caregiver)

67. Are you unemployed or without regular income?

☐ Yes ☐ No ☐ Unknown

68. 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 ☐ Somewhat ☐ A little bit ☐ Quite a bit ☐ Very much

69. During the past 12 months, have you had a dental problem which you would have liked to see a dentist about but you did NOT see a dentist?

☐ Yes ☐ No

If no, what is the main reason you have not visited the dentist in the last 12 months?

☐ Fear, apprehension, nervousness, pain, dislike going
☐ Cost
☐ Do not have/know a dentist
☐ Did not have time
☐ Cannot get to the office (no appointments available)
☐ Have not thought about it
☐ Cannot get to the office/clinic (too far away, no transportation)
☐ Other priorities

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

☐ Yes ☐ No

71. In the past 12 months, have you gone to a hospital emergency room for:

☐ Dental pain/infection ☐ Dental trauma/accident ☐ Other

Other: _____

72. On a scale of 0-10, how strongly do you agree with the following statement: "I can manage and control my health problems?"

☐ 10 – Very high
☐ 9
☐ 8
☐ 7
☐ 6
☐ 5
☐ 4
☐ 3
☐ 2
☐ 1
☐ 0 – Very Low
☐ N/A – You have no health problems or risks to your health

Physical Health

73. Have you ever been told by a doctor or health care provider that your child has any of these conditions? (check all that apply)

☐ Yes ☐ No

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

If you have had a **transplant**: How long ago was the transplant?

☐ More than one year ago ☐ In the past 12 months ☐ On the transplant list

☐ Unknown

Does your child have any other conditions not listed above? _____

_____

_____

74. On a scale of 0–10, where 0 = Health problems had no effect and 10 = Health problems had an effect, how much did your child's health problems affect their ability to do their regular daily activities or go to school during the past 7 days?

☐ 0 (Health problems had no effect on daily activity) ☐ 1-3 ☐ 4-6

☐ 7-10 (Health problems completely prevented me from daily activity ☐ Unknown

Behavioral Health

75. Have you ever been told by a health care provider that your child has any of these behavioral health conditions?

☐ ADD/ADHD ☐ Autism ☐ Depression ☐ Eating disorder

☐ Learning disability

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

_____

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

☐ Yes ☐ No ☐ Unknown

What type of treatment did your child receive?

_____

_____

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

☐ Yes ☐ No ☐ Unknown

78. Would you like help getting treatment for your child for a behavioral health disorder?

☐ Yes ☐ No ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

What are your concerns for your child? _____

80. How often do you feel that you lack companionship?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

81. Is your child aged 12 years or over?

☐ Yes ☐ No ☐ Unknown

During the past two weeks, how much (or how often) has your child had problems with sleeping, that is, 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

During the past two weeks, how much (or how often) has your child had less fun doing things than he/she used to?

☐ Not at all ☐ Rare ☐ Less than a day or two
☐ Several days ☐ More than half the days ☐ Nearly every day ☐ Unknown

During the past two weeks, how much (or 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 two weeks, has your child had an alcoholic beverage (beer, wine, liquor, etc.)?

☐ Yes ☐ No ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

In the past two 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

82. Over the last 2 weeks, how often have you been bothered by the following problem: Little interest or no pleasure in doing things?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

83. Over the last 2 weeks, how often have you been bothered by the following problem: Feeling down, depressed or hopeless?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

General Information

84. Assessment Completed Date:_____/_____/_____

85. Assessment Completed By (*your name here*)_____

86. Relationship to member:

☐ Self ☐ Member representative with permission ☐ Parent/Guardian
☐ Envolve ☐ Health Plan ☐ Vendor ☐ Other

If other relationship to member, please explain:_____

87. Assessment Interval:

☐ Initial ☐ Yearly ☐ Change of condition ☐ Unknown

88. Name of agency completing assessment?

_____

89. Credentials of staff completing assessment?
☐ RN ☐ LCPC ☐ LCSW ☐ Advanced Practitioner ☐ LVN/LPN ☐ MD/DO
☐ Pharmacist ☐ Other Credentials ☐ None

90. If other, please provide credentials:
_____

91. By what method was the HRS information obtained?
☐ Phone ☐ In-person/home visit ☐ Form faxed/mailed in ☐ Information not obtained

92. Was assistive (TDD/TYY) equipment used to complete this assessment?
☐ Yes ☐ No ☐ Unknown

93. Was a translator used to complete this assessment?
☐ Yes ☐ No ☐ Unknown

Translator information: _____

94. Was information obtained from a non-parent/non-guardian?
☐ Yes ☐ No ☐ Unknown

95. ATTESTATION: I have reviewed the Documentation Module. The member's POA and/or Authorized Representative information is updated in the Document Summary section.
☐ Yes ☐ No ☐ N/A

96. ATTESTATION: I have reviewed the Member Demographics module. The member's General Information section and Contact Information section have been transcribed and updated with the information obtained in this assessment.
☐ Yes ☐ No ☐ N/A

97. ATTESTATION: I have reviewed and updated the Member Contact Summary with caregiver/POA information if applicable.
☐ Yes ☐ No ☐ N/A

98. ATTESTATION: I have reviewed the Provider Contacts Summary module and the information is up to date and accurate.
☐ Yes ☐ No ☐ N/A

99. ATTESTATION: I have reviewed the Member's Diagnosis module and the member's information is up to date and accurate.
☐ Yes ☐ No ☐ N/A

100. ATTESTATION: I have reviewed all of the Member's Care Alerts.
☐ Yes ☐ No ☐ N/A