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 sex?

☐ Female ☐ Male ☐ I prefer not to answer

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

_____

Global Health / Safety

13. In general, how would you rate your child's health?

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

Please explain the reason for your child's poor health rating: _____

_____

14. 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

What changes are you ready to make for your child's health? _____

_____

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

☐ Yes ☐ No ☐ Unknown

16. 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

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

_____

18. 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? _____

19. 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

20. 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

21. 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

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

☐ Yes ☐ No ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

24. 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

25. 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.*

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

☐ Yes ☐ No ☐ Unknown

27. 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?

_____

28. Is your child pregnant?

☐ Yes ☐ No ☐ Unknown

What is your child's due date?

_____

29. 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

30. 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

31. 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

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

☐ Yes ☐ No ☐ Unknown

33. What prevents your child from taking their medicines?

_____

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

☐ Yes ☐ No ☐ Sometimes ☐ Unknown

35. 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.

36. 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

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

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

☐ Yes - Overweight ☐ Yes - Underweight ☐ No ☐ Unknown

39. Are you interested in working toward a healthier weight for your child?

☐ Yes ☐ No ☐ Unknown

40. 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

41. 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.

42. 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.

43. 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.

44. 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

45. 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).

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

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly Often ☐ Frequently

47. 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: _____

48. 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:
_____

49. Are you on dialysis?
☐ Yes ☐ No ☐ Choose not to answer

50. Are you considered homebound? (Homebound means that leaving your home takes considerable and taxing effort)
☐ Yes ☐ No ☐ Choose not to answer

Social Concerns

51. Do you currently have concerns about having enough money to pay for your basic needs?
☐ Yes ☐ No ☐ Unknown

Please explain your concerns about money to pay for basic needs: _____
_____
_____

52. Do you feel safe in your daily life?
☐ Yes ☐ No ☐ Unknown

Please explain any safety concerns you have: _____
_____
_____

53. 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

Please explain: _____

_____

_____

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

☐ Yes ☐ No ☐ Unknown

55. 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

56. 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

57. 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

58. 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

59. 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 ☐ Car broke down
☐ Person who usually takes me is unavailable ☐ Costs too much
☐ I do not have a personal vehicle ☐ Transit system not available

60. 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

61. 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

62. 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

63. 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)

64. Are you unemployed or without regular income?

☐ Yes ☐ No ☐ Unknown

65. 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

66. 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

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

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

☐ Yes ☐ No

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

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

Other: _____

69. 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

70. 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? _____

_____

_____

71. 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

72. 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?

_____

73. 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?

_____

_____

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

☐ Yes ☐ No ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

What are your concerns for your child? _____

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

☐ Never ☐ Rarely ☐ Sometimes ☐ Often

78. 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

79. 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

80. 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

81. Assessment Completed Date:_____/_____/__

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

83. Relationship to member:
☐ Self ☐ Member representative with permission ☐ Parent/Guardian
☐ Envolve ☐ Health Plan ☐ Vendor ☐ Other

If other relationship to member, please explain:_____

84. Assessment Interval:
☐ Initial ☐ Yearly ☐ Change of condition ☐ Unknown

85. Name of agency completing assessment?
_____

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

87. If other, please provide credentials:
_____

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

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

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

Translator information: _____

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

92. 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

93. 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

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

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

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

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