







Health Risk Screening - Infant (Less than Six Months)

Me	ember Information:					
1)	1) Preferred Mailing Address:					
2)	Preferred Phone Number: +_ ()					
3)	Race (Check Whichever Applies):					
	American Indian / Alaska Native		Asian			
	Black / African American		Native Hawaiian / Other Pacific Islander			
	White		Other			
	I prefer not to answer		Unknown			
 a. If you chose other, list race here: b. If you chose Native American: Are you eligible to receive Indian Health Services? Yes No 						
4)	Ethnicity:					
Hispanic or Latino I prefer not to answer Not Hispanic or Latino Unknown						
a. If you chose other, list ethnicity here:						
5)	Language: English Other Unknown					

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

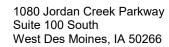






1080 Jordan Creek Parkway Suite 100 South West Des Moines, IA 50266

6) V	What is your gend	der identity?		
	Female	Male		Non-Binary
	Transgender	Prefer No	ot to Answ	er
_\ _				
7) L	o you have any	problems with	your hear	ing, vision, or speech requiring special services?
		Yes	No	Unknown
	a. If yes, expl	lain:		



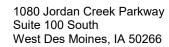






Birth History

8) Was your child born by vaginal delivery or C-Section?				
Vaginal C-Section Unknown				
9) Was your child born prior to 39 weeks gestation?				
Yes Unknown				
a. If yes, at what week of pregnancy was your child born?				
10) In this pregnancy, were there any problems?				
Yes No Unknown				
a. If you answered yes, what problems?				
11) In this pregnancy, did labor start on its own?				
Yes Unknown				
a. If yes, why was it induced early?				
12) What was your child's birth weight? lbs oz.				
13) Did your child have to spend any extra time in the hospital after birth?				
Yes Unknown				
a. If yes, how much extra time? weeks				
14) Did you try breastfeeding or pumping breast milk in the hospital after birth?				
Yes Unknown				



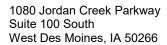






Global Health / Safety:

15)	15) In general, how would you rate your child's health?						
	Exceller	nt	V	ery Good			
	Good		F	air			
	Poor						
	a. If v	you chose poor, pleas	se explain	:			
	•	, 1 ,1	'				
16)	On a sca	ale of 0 – 10, how rea	dy are yo	u to make changes for your child's health? (0 = Not			
	ready to	change, 10 = Very rea	ady for ch	ange)			
	a. If	fyou chose 8 – 10, w	hat chang	es are you ready to make for your child?			
17)	Does yo	our child have a docto	r or healtl	n care provider?			
		Yes	No	Unknown			
	a. If yes, what is your child's doctor or health care provider's name?						
18)	Has you	ır child seen their doc	tor or hea	alth care provider since birth?			
		Yes	No	Unknown			
19)	Are you	r child's immunizatior	ns up to da	ate?			
		Yes	No	Unknown			
20)	How ma	ny times has your chi	ld been to	the hospital in the last 3 months?			
		None		One Time			
		2 Times		3 or More Times			



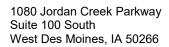






21) How many times has your child been to the Emergency Department in the last 3 months?					
None One Time					
2 Times 3 or More Times					
22) How many medicines is your child currently taking that were prescribed by their doctor or					
health care provider? Prescriptions					
a. If your child is taking any prescriptions, does anything ever prevent them from taking					
their medicine the way their doctor or health care provider wants them to?					
Yes No Unknown					
i. If yes, what prevents your child from taking their medicine?					
b. Do you ever forget to give your child their medicines?					
Yes No Unknown					
23) What is your child's current weight? lbs.					
24) Have your or a health care provider been concerned about your child's weight?					
Yes (overweight) Yes (underweight) No					
25) What are you feeding your baby now?					
Breast Milk Only Breast Milk + Formula					
Formula Only Other					

a. If other, what type of feeding is your baby receiving?

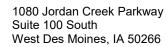








26) Does your child always use a seat belt or sit in a car seat when you drive or ride in the car				
Yes No Unknown				
27) Does your child have a safe place to sleep? (Ideally in parents' room on a separate firm surface. The baby should be placed on their back and not have any soft bedding or toys in				
their sleeping area).				
Yes No Unknown				
28) Does your child live with anyone who is a regular smoker?				
Yes No Unknown				



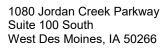






Social Concerns:

29) In the last 12 months, did you worry your food would run out before you got money to buy
more?
Yes No Unknown
30) In the last 12 months, did the food you bought just not last and you didn't have money to get more?
Yes Unknown
31) In the past 2 months have you been living in stable housing that you own, rent, or stay in as part of a household?
part of a flousofiold:
Yes Unknown
32) Do you currently have concerns about having enough money to pay for your basic needs?
Yes Unknown
a. If yes, please explain these concerns:
33) Do you feel safe in your home and around all the people in your life?
Yes Unknown
a. If no, please explain any safety concerns you have:

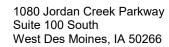








34) Do you know of any really sca or anyone in your family?	ary or upsetting things that have	happened to you, your child,
Yes	No Unknown	
a. If yes, please explain: _		
35) Do you have access to a safe,	reliable telephone?	
36) Do you ever have any problenYes37) Has a healthcare provider eve	No Unknown	
(Check all that apply)	, ,	
Bone / Growth Disorder	Cancer	Cystic Fibrosis
Developmental Delay	Eczema	Heart Disease
Kidney Disease	Premature Birth	Seizures
Sickle Cell Disease	Transplant	
38) If your child has any other dis	order not listed above, please fi	ll it in here:



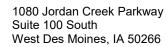






Behavioral Health:

39) During the past month, have you often been bothered by feeling down, depressed, or
hopeless?
Yes No Unknown
40) During the past month, have you been bothered by little interest or pleasure in doing
things?
Yes No Unknown
41) Do you have concerns about your child's learning, behavior, or development?
Yes No Unknown
a. If yes, what are your concerns with your child?

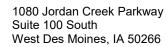








Supplemental Assessment:

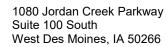








46)) In	the past year, have you or a	iny f	amily members y	ou l	ive with	n been unable to get any of the
following when it was really needed? Check all that apply:							
		Food		Clothing			Dental Care
		Mental Health Care		Utilities			Eye-Care
		Child Care Phone		Phone			Medical Care
	Transportation						
47)) If y	ou have trouble getting trar	ıspo	rtation when you	nee	ed it, wh	nat is the MAIN reason you
	car	nnot get to where you want t	o go	?			
		I do not have trouble getti	ng tr	ransportation		Car br	oke down
	Person who usually takes me is unavailable Costs too much				too much		
	I do not have a personal vehicle			cle	Transit system unavailable		
48) 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 Som	ewh	at			
		A little bit Quite	e a b	it			
_		Very much					

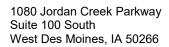








49) How often do you feel unsafe in your neighborhood?					
Never Rarely					
Sometimes Fairly often					
Frequently					
50) In the past year, have you been afraid of your partner or e	x-partner?				
Yes No					
Unsure I haven't had a partner in th	e last year				
51) Notes:					
 					
52) During the past 12 months, have you had a dental probler	n 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	Cost				
Do not have/know a dentist	Did not have the time				
Cannot get to the office / no appointment available	Other priorities				

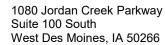








53) In the past 12 months, have you gone to a hospital emergency room for a dental problem?
Yes No
a. If yes, check which of the following reasons you went to the hospital emergency room:
Dental Pain/Infection Dental Trauma/Accident
Other
i. If you chose other, please explain:
54) On a scale of $1-10$, 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:

55) Date of Assessment:/
56) Assessment Completed By (Your Name Here)
57) Relationship to member:
(Self, Parent / Guardian, Envolve, Health Plan, Vendor, Etc.)
58) Enroll Member in Program now?
Yes No
59) Member / Guardian agrees to participate in program?
Yes No N/A