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

Health Risk Screening – Infant (Less than Six Months)

Member Information:

1) Preferred Mailing Address: _____

2) Preferred Phone Number: +_ (___) ___ - ____

3) 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:** 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
- ☐ Other

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

5) Language:

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

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

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6) What is your gender identity?

☐ Female ☐ Male ☐ Non-Binary
☐ Transgender ☐ Prefer Not to Answer

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

☐ Yes ☐ No ☐ Unknown

a. If yes, explain: _____

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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 ☐ No ☐ 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 ☐ No ☐ 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 ☐ No ☐ Unknown

a. If yes, how much extra time? _____ weeks

14) Did you try breastfeeding or pumping breast milk in the hospital after birth?

☐ Yes ☐ No ☐ Unknown

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Global Health / Safety:

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

☐ Excellent ☐ Very Good
☐ Good ☐ Fair
☐ Poor

a. If you chose poor, please explain: _____

_____

16) On a scale of 0 – 10, how ready are you to make changes for your child's health? (0 = Not ready to change, 10 = Very ready for change) _____

a. If you chose 8 – 10, what changes are you ready to make for your child? _____

17) Does your child have a doctor or health care provider?

☐ Yes ☐ No ☐ Unknown

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

_____

18) Has your child seen their doctor or health care provider since birth?

☐ Yes ☐ No ☐ Unknown

19) Are your child's immunizations up to date?

☐ Yes ☐ No ☐ Unknown

20) How many times has your child been to the hospital in the last 3 months?

☐ None ☐ One Time
☐ 2 Times ☐ 3 or More Times

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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?

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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

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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 ☐ No ☐ 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?

☐ Yes ☐ No ☐ Unknown

32) 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: _____

_____

_____

33) 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: _____

_____

_____

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34) 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: _____

_____

_____

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

☐ Yes ☐ No ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

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

(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 disorder not listed above, please fill it in here:

_____

_____

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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? _____
_____
_____

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Supplemental Assessment:

42) How many family members, including yourself, do you currently live with? _____

43) 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

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

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

45) What is your current work situation?

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

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46) 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

47) 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

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
- ☐ A little bit
- ☐ Very much
- ☐ Somewhat
- ☐ Quite a bit

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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
- ☐ Unsure
- ☐ I haven't had a partner in the last year

51) Notes: _____

_____

_____

52) 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
- ☐ Cost
- ☐ Do not have/know a dentist
- ☐ Did not have the time
- ☐ Cannot get to the office / no appointment available
- ☐ Other priorities

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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)

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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