# Health Risk Screening: Infant (Less than 6 Months)

**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 ☐ I prefer not to answer ☐ Unknown

Please list other preferred language: _____

7. 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: _____

8. Do you need interpretation services?

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

9. In what language do you prefer written materials?

☐ English ☐ Spanish ☐ I prefer not to answer ☐ Other

Please list other language for written materials: _____

10. 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

11. What is your child's sex?

☐ Male ☐ Female ☐ I prefer not to answer

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

_____

**Birth History**

13. Was your child born by vaginal delivery or C-Section?

☐ Vaginal delivery ☐ C-section ☐ Unknown

14. Was your child born prior to 39 weeks gestation?

☐ Yes ☐ No ☐ Unknown

At what week of pregnancy was your child born?

☐ 38 weeks
☐ 37 weeks
☐ 36 weeks
☐ 35 weeks
☐ 34 weeks
☐ 33 weeks
☐ 32 weeks
☐ 31 weeks
☐ 30 weeks
☐ 29 weeks
☐ 28 weeks
☐ 27 weeks
☐ 26 weeks
☐ 25 weeks
☐ 24 weeks
☐ 23 weeks
☐ 22 weeks
☐ Unknown

15. In this pregnancy, were there any problems?

☐ Yes ☐ No ☐ Unknown

What problems occurred during this pregnancy? _____

_____

16. In this pregnancy, did labor start on its own?

☐ Yes ☐ No ☐ Unknown

Why was the delivery induced early?

☐ Diabetes ☐ Inadequate growth of the baby ☐ Non-medical reason

☐ Other ☐ Placental abruption (separation) ☐ Preeclampsia/high blood pressure

☐ Premature rupture of membranes ☐ Scheduled C-section ☐ Unknown

What was the reason for the early delivery?

_____

17. What was your child's birth weight? _____ lbs. _____oz.

18. Did your child have to spend any extra time in the hospital after birth?

☐ Yes ☐ No ☐ Unknown

If yes, how much extra time did your child have to spend in the hospital after birth?

☐ Less than 1 week
☐ 2 weeks
☐ 3 weeks
☐ 4 weeks
☐ 5 weeks
☐ 6 weeks
☐ More than 6 weeks
☐ Unknown

19. What was your child fed in the hospital after birth?

☐ Breast milk only ☐ Breast milk plus formula ☐ Formula only ☐ Unknown

**Global Health/Safety**

20. 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: _____

_____

21. On a scale of 0–10, how ready are you to make changes to 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? _____

_____

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

☐ Yes ☐ No ☐ Unknown

If you answered yes, what is your child's doctor or health care provider's name? _____

23. 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

24. Has your child seen their doctor or health care provider since birth?

☐ Yes ☐ No ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

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

☐ Yes ☐ No ☐ Unknown

*Children get most of their vaccines during the first 2 years of life. That's because the diseases these vaccines prevent are very harmful to young children.*

27. 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

28. 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

29. 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

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

☐ Yes ☐ No ☐ Unknown

What prevents your child from taking their medicines?

_____

Do you ever forget to give your child their medicines?

☐ Yes ☐ No ☐ Sometimes ☐ Unknown

30. What is your child's weight? _____ lbs.

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

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

32. What are you feeding your baby now?

☐ Breast milk only ☐ Breast milk plus formula ☐ Formula ☐ Other

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

33. 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.*

34. Does your baby 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

35. 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).*

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

☐ Never ☐ Rarely ☐ Sometimes ☐ Fairly often ☐ Frequently

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

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

Notes: _____

38. 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:
_____

39. Are you on dialysis?

☐ Yes ☐ No ☐ Choose not to answer

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

☐ Yes ☐ No ☐ Choose not to answer

**Social Concerns**

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

☐ Yes ☐ No ☐ Unknown

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

42. Do you feel unsafe in your daily life?

☐ Yes ☐ No ☐ Unknown

Please explain any safety concerns you have: _____
_____
_____

43. 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: _____
_____
_____

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

☐ Yes ☐ No ☐ Unknown

45. 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

46. 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

47. 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

48. In the past 2 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

49. 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

50. 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

51. 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

52. 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

53. 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)

54. Are you unemployed or without regular income?

☐ Yes ☐ No ☐ Unknown

55. 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

56. 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

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

☐ Yes ☐ No

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

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

Other: _____

59. 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**

60. Have you ever been told by a doctor or health care provider that your child has any 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 (not trait) ☐ Transplant

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

_____

_____

**Behavioral Health**

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

☐ Yes ☐ No ☐ Unknown

What are your concerns with your child? _____

_____

62. How often do you feel that you lack companionship?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often

**General Information:**

63. Assessment Completed Date:_____/_____/_____

64. Assessment Completed By (Name):_____

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

If other relationship to member, please explain:_____

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

67. Name of agency completing assessment?
_____

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

69. If other, please provide credentials:
_____

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

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

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

Translator information: _____

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

74. 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

75. 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

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

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

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

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