West Virginia Department of Health and Human Resources
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
HealthCheck Program Preventive Health Screen

11, 12, 13 and 14 Year Form

Name_____DOB_____Age_____Sex: M F Wt_____Ht_____BP_____Temp_____Pulse_____Screen Date_____

Allergies: □ NKDA _____ Current Meds: □ None_____

Accompanied by: □ Parent □ Grandparent □ Foster parent/organization □ Other _____

History: □ No change
Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses, or visits to other providers:

Social/Family History: ✓ *Check those that apply*
□ No change
□ Family situation change

Caretaker(s) working outside home? □ Yes □ No
Child care? □ No □ Yes _____
Other changes since last visit:

Current Health Indicators: ✓ *Check those that apply*
□ No change □ LMP_____ □ N/A
Changes since last visit:

□ **GROWTH PLOTTED ON GROWTH CHART**
□ **BMI CALCULATED AND PLOTTED ON BMI CHART**
□ Normal elimination □ Normal sleep patterns
Comments:

Nutrition: □ Normal eating habits
□ Vitamins:_____
Comments:

□ Passive Smoking Risk: □ Yes □ No
✓ *Check those that apply*
Hemoglobin/Hematocrit Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Dyslipidemia Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

Tuberculosis Risk: □ Low risk □ High risk
See Periodicity Schedule for risk indicators

□ ***Depression Screen:** ✓ *Check those that apply*
Feelings over the past 2 weeks:
Little interest or pleasure in doing things: □ Not at all
□ Several days □ More than ½ the days □ Nearly every day
Feeling down, depressed, or hopeless: □ Not at all
□ Several days □ More than ½ the days □ Nearly every day
**If Positive see Periodicity Schedule*

□ **Psychosocial/Behavioral Screen:** ✓ *Check those that apply*
Appropriate behavior: □ Yes □ No
Fun activities: _____
_____

Friend(s): □ Yes □ No Concern(s): □ Yes □ No
□ Thoughts/plans to harm □ Self □ Others □ Animals
□ Trouble at school □ Trouble with the law
Behavioral concerns/comments: □ Yes □ No

Risk indicators: ✓ *Check those that apply* □ None identified
□ Poor self image □ Lack of physical activity
□ Weight or height concerns_____
□ Tobacco use: □ Cigarettes/# per day_____ □ Chew
□ *Alcohol use_____ □ *Other drugs_____
**If positive see Periodicity Schedule*
□ Peer pressure to do things you don't want to do:
_____
□ Pressure to have sex □ Inappropriate touching
□ Does not wear protective gear, including seat belts
□ Access to firearms □ Has a firearm
□ Witnessed violence □ Threatened with violence
□ Excessive television/video game use (>2 hrs. per day)
School: Grade_____
□ Attends school regularly
□ Special classes_____
Likes most about school:_____
_____
Likes least about school: _____
_____
Proud of:_____
_____
Participates in activities_____
Plans after high school_____
Family/Sexuality:
□ Gets along with other family members
If you could, how would you change your life?
_____
home? _____
family?_____

□ Sex education/questions
Sexually active? □ Yes □ No *STI/HIV_____□ N/A
**If positive see Periodicity Schedule*
Method of contraception_____ □ N/A

□ **Vision Acuity Screen** (Obj @ 12 yrs) R_____ L_____
□ **Hearing Screen** as indicated by risk screen: 20db@
R ear: _____500HZ ____1000HZ ____2000HZ ____4000HZ
L ear: _____500HZ ____1000HZ ____2000HZ ____4000HZ

Oral Health Screen
Date of last dental visit_____
□ Current oral health problems:

Physical Examination: ✓= *Normal limits*

□ General Appearance		□ Skin
□ Neurological		□ Reflexes
□ Head		□ Neck
□ Eyes		□ Ears
□ Nose		□ Oral Cavity/Throat
□ Lungs	□ Heart	□ Pulses
□ Abdomen		□ Genitalia
□ Back		□ Extremities

Abnormal Findings and Comments:
Possible Signs of Abuse □ Yes □ No

Health Education/Anticipatory Guidance:
□ Discussed □ Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, risk behaviors, sexuality, injury and violence prevention, mental health, substance use/abuse, social competence, responsibility, family relationships, community interaction, school achievement, and health care transition from adolescence to adulthood in the medical home (beginning at 14 years)
Other:

Assessment: □ **Well Child** □ **Other diagnosis**
□ **Risk indicators reviewed/screen complete**

Plan/Referrals:
For treatment plans requiring authorization, please complete page 2 on the reverse.

Immunizations: □ **UTD** □ Given, see vaccine record
Labs:

Referrals*: □ Behavioral/Mental health □ Dentist □ Vision
□ Hearing □ CSHCN □ FP **1-800-642-9704**
***See Provider Manual for automatic referrals*
□ Other referral(s)

Follow Up/Next Visit: □ 12 years of age □ 13 years of age
□ 14 years of age □ 15 years of age □ Other

_____
Please print Name of Facility or Clinician

_____
Signature of Clinician/Title