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

9 & 10 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
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

□ **Behavior/Mental Health Screen:** *✓ Check those that apply*
Appropriate behavior: □ Yes □ No
Fun activities: _____
_____
Friend(s): □ Yes □ No
Concern(s): □ Yes □ No
Feelings: □ Content
□ Sad □ Less than a week □ More than a week
□ Angry □ Less than a week □ More than a week
□ Down/depressed □ Less than a week □ More than a week
□ 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 drug _____
□ Peer pressure to do things you don't want to do:
_____
□ 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
□ Math at grade level □ Reads at grade level
Likes most about school:_____
_____
Likes least about school: _____
_____
Proud of:_____
_____
Participates in activities_____
□ Special classes_____

Family/Sexuality:
□ Gets along with other family members
If you could, how would you change your life?
_____
home? _____
family?_____
□ Sex education/questions

□ **Vision Acuity Screen** (Sub @ 9yrs, Obj @ 10 yrs)
R_____ L_____

□ **Hearing Screen** (Sub @ 9yrs, Obj@ 10yrs)
R ear: 25 db @____500HZ
20 db@ ____1000HZ ____2000HZ ____4000HZ
L ear: 25 db @____500HZ
20 db@ ____1000HZ ____2000HZ ____4000HZ

Oral Health Screen
Date of last dental visit_____
Water source:
□ Public □ Well □ Tested
Fluoride □ Yes □ No
□ 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, social competence, family relationships, and community interaction
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 **1-800-642-9704**
*****See Provider Manual for automatic referrals*
□ Other referral(s)

Follow Up/Next Visit: □ 10 years of age □ 11 years of age
□ Other

_____
Please print Name of Facility or Clinician

_____
Signature of Clinician/Title

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BUREAU FOR PUBLIC HEALTH