Screen Date____________________

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

9 and 10 Year Form

Name________________________________ DOB________________ Age__________ Sex: ☐ M ☐ F

Weight ________ Height________ BMI________ Pulse________ BP________ Resp________ Temp________ Pulse Ox (*optional*)________

Allergies ☐ NKDA ________________________________

Current meds ☐ None________________________________

☐ Foster Child ____________ ☐ Kinship Placement____________ ☐ Child with special health care needs____________ ☐ IEP/section 504 in place____________

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization____________________ ☐ Other ____________________

Medical History

☐ Initial Screen ☐ Periodic screen

☐ Family health history reviewed ____________________

____

Currently receiving mental/behavioral health services? ☐ Yes ☐ No

____

Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:____________________

____

____

Psychosocial/Behavioral

What is your family living situation____________________

____

Family relationships ☐ Good ☐ Okay ☐ Poor

Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No ____________

____

Are parents/caregivers working outside home? ☐ Yes ☐ No

Child care/after school care ____________________

____

Grade in school____________________

Favorite subject____________________

Any problems?____________________

Activities outside school____________________

Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

Exposure to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

☐ Drugs (prescription or otherwise)____________________

☐ Access to firearm(s)/weapon(s) ☐ Has a firearm(s)/weapon(s)

Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

Do you wear protective gear, including seat belts? ☐ Yes ☐ No

☐ Excessive television/video game/internet/cell phone use

Concerns about speech, learning, social or motor skills ____________

____

Concerns about depression and/or anxiety____________________

____

Traumatic Stress Reactions/PCL-C

Positive screen = numbered responses 4 or greater

Feelings over the past 2 weeks: (✓ *Check one for each question)*

Repeated, disturbing memories, thoughts, or images of a stressful experience from the **past**? ☐ Not at all (0) ☐ A little bit (1) ☐ Moderately (2) ☐ Quite a bit (3) ☐ Extremely (4)

Feeling very upset when something reminded you of a stressful experience from the **past**? ☐ Not at all (0) ☐ A little bit (1) ☐ Moderately (2) ☐ Quite a bit (3) ☐ Extremely (4)

How much **stress** are you and your family under **now**?

☐ None ☐ Slight ☐ Moderate ☐ Severe

What kind of stress? (✓ *Check those that apply)*

☐ Relationships (partner, family and/or friends) ☐ School/work

☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or sexual) ☐ Family member incarcerated ☐ Lack of support/help

☐ Financial ☐ Emotional loss ☐ Health insurance

☐ Other____________________

____

Indicators of Serious Emotional or Behavioral Disturbance (✓ *Check those that apply)*

If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).

☐ Talks or repeatedly thinks about harming self, killing self, or wanting to die

☐ Frequently mean to other people or animals

☐ Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)

☐ Behavior frequently typically inappropriate and causes problems for self or others (i.e., fighting, belligerency, promiscuity)

☐ Frequent use of profane, vulgar, or curse words to household members

☐ Deliberate damage to home

☐ Frequently truant (i.e., approximately once every 2 weeks or for several consecutive days)

☐ Marked changes in moods that are generally intense and abrupt

☐ Friendships change to mostly substance users

☐ Preoccupying cognitions or fantasies with bizarre, odd, or gross themes

☐ Currently at risk of confinement because of frequent or serious violations of law

☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources

General Health

☐ Growth plotted on growth chart

☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep

Normal eating habits? ☐ Yes ☐ No

Fruits/vegetables/lean protein per day____________________

☐ Vitamins____________________

☐ Normal elimination____________________

☐ Physical activity/exercise an hour most days

Type of physical activity/exercise ____________________

Normal sleeping patterns? ☐ Yes ☐ No

Hours of sleep each night?____________________

Oral Health

Date of last dental visit____________________

Current oral health problems ____________________

Water source ☐ Public ☐ Well ☐ Tested

Fluoride supplementation ☐ Yes ☐ No

Vision Acuity Screen: *(Objective 10 years)*

R ____________ L ____________

Wears glasses? ☐ Yes ☐ No

Continue on page 2

Name________________________________ DOB____________________ Age____________ Sex: ☐ M ☐ F

Hearing Screen (*Objective 10 years*)
20db@
R ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ
L ear: _____ 500HZ ____ 1000HZ ____ 2000HZ ____ 4000HZ
Wears hearing aids? ☐ Yes ☐ No

***Anemia Risk (Hemoglobin/Hematocrit)**
☐ Low risk ☐ High risk

***Tuberculosis Risk**
☐ Low risk ☐ High risk

***Dyslipidemia Risk**
☐ Low risk ☐ High risk
Fasting lipoprotein required once between 9 and 11 years

****See Periodicity Schedule for Risk Factors***

Physical Examination *(N=Normal, Abn=Abnormal)*

General Appearance	☐ N	☐ Abn	____________
Skin	☐ N	☐ Abn	____________
Neurological	☐ N	☐ Abn	____________
Reflexes	☐ N	☐ Abn	____________
Head	☐ N	☐ Abn	____________
Neck	☐ N	☐ Abn	____________
Eyes	☐ N	☐ Abn	____________
Ears	☐ N	☐ Abn	____________
Nose	☐ N	☐ Abn	____________
Oral Cavity/Throat	☐ N	☐ Abn	____________
Lung	☐ N	☐ Abn	____________
Heart	☐ N	☐ Abn	____________
Pulses	☐ N	☐ Abn	____________
Abdomen	☐ N	☐ Abn	____________
Genitalia	☐ N	☐ Abn	____________
Back	☐ N	☐ Abn	____________
Hips	☐ N	☐ Abn	____________
Extremities	☐ N	☐ Abn	____________

If female:
LMP_______________ ☐ Regular ☐ Irregular
Bleeding ☐ Normal ☐ Heavy
Cramping ☐ No ☐ Slight ☐ Severe

Possible Signs of Abuse/Neglect ☐ Yes ☐ No

Age Appropriate Health Education/Anticipatory Guidance *(Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)*

Social Determinants of Health, Development and Mental Health, School, Physical and Growth Development, and Safety
☐ Discussed ☐ Handouts Given

Questions/Concerns/Notes

____

Plan of Care

Assessment
☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

Labs
☐ Hemoglobin/hematocrit *(if high risk)*
☐ TB skin test *(if high risk)*
☐ **Fasting lipoprotein (*once between 9 and 11 years and/or high risk)***
☐ Other ________________________________

Referrals
☐ Mental/behavioral health/trauma - **Help4WV.com/1-844-435-7498**
☐ Dental ☐ Vision ☐ Hearing
☐ Other ________________________________

☐ Children with Special HealthCare Needs (CSHCN)
1-800-642-9704

Medical Necessity
For treatment plans requiring authorization, please complete page 3. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.

Follow Up/Next Visit ☐ 10 years of age ☐ 11 years of age
☐ Other________________________________

☐ Screen has been reviewed and is complete

____
Please Print Name of Facility or Clinician

____
Signature of Clinician/Title

West Virginia Department of Health & Human Resources Bureau for Public Health