

EPSDT/HealthCheck Health History Form

0-6 Years

Patient Name: _____ **Date of Birth:** _____ **Age:** _____

Your Name: _____ **Relationship to child:** _____

Pregnancy and Birth

Medical problems during pregnancy? _____
 In utero drug exposure? _____
 Where was the child born? _____
 Delivered by: Vaginal C-section
 Why C-section? _____
 Birth Weight: _____ Birth Length: _____
 Full Term (≥ 37 weeks gestation) Preterm (≤ 36 weeks gestation)
 NICU stay: _____ weeks
 Other problems in the newborn period? _____

Excessive television/video game/internet/cell phone use
 Hours per day: _____ Who supervises usage? _____
 Utilize a car or booster seat? Yes No
 Wears protective gear, including seat belts? Yes No
 Any concerns about lead exposure (old home, plumbing, peeling paint)? Yes No

Medications

Current medications and dose: _____
 Vitamins: _____
 Herbs/home remedies: _____
 Over the counter: _____

Allergies/reactions to medications or vaccines: _____

Infancy and Childhood

Has your child ever been treated for or diagnosed with:
 Asthma or wheezing _____
 Pneumonia _____
 Lung problems _____
 Heart murmur _____
 Anemia _____
 Recurrent ear infections _____
 Hearing problems _____
 Vision or eye problems _____
 Urinary tract infections _____
 Stomach or digestive problems _____
 Seasonal allergies or eczema _____
 Seizures _____
 Broken bone(s) _____
 Learning disability _____

 Other chronic medical problems _____

Nutrition and Feeding

Has your child had any feeding/dietary problems? _____

 Unexplained weight gain
 Unexplained weight loss
 Food allergies: _____
 Participates in WIC

Dental

Problems with teeth or gums
 Bad breath
 Has your child been seen by a dentist? Yes No
 If so, date of last exam: _____
 Why did he/she see the dentist? _____
 Water source: City Well

Has your child ever been hospitalized?
 No Yes Why? _____
 Previous surgeries: _____
 Please list any specialists, including counselors, your child is currently seeing and reason: _____

Family Medical History

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug and alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnosed mental condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____			

Developmental

Do you have concerns about any of the following:
 The way your child uses his/her arms, fingers or legs
 Speech problems
 Vision (Are you concerned about your child's vision?)
 Hearing (Are you concerned about your child's hearing?)

Social Emotional/Stress Indicators

Parent(s)/Caretaker(s) working outside home? Yes No
 Child care? Yes No
 Who do you call for help? _____
 Has your child lived anywhere but with parents/caregivers? Yes No
 Is there stress in the home? Yes No
 Does your child have problems with sleeping or nightmares? Yes No
 Does your child have a bad temper/ breath holding/jealousy? Yes No
 Does your child bite their nails or suck their thumb? Yes No
 Does your child have depression/anxiety? Yes No
 Does your child have ADD/ADHD? Yes No

Other Concerns/Issues:

Exposure Risks

Passive smoke Cigarettes E-Cigs Chew
 Alcohol Other drugs _____
 Access to weapons Has a weapon(s)

Reviewed by: _____
Date: _____

Some responses may indicate adverse childhood experiences and may require further evaluation. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. For assistance phone 844-HELP4WV (844-435-7498).

Patient Name: _____ Date of Birth: _____ Age: _____

Your Name: _____ Relationship to child: _____

Childhood

Has your child ever been treated for or diagnosed with:

- Asthma or wheezing _____
- Pneumonia _____
- Lung problems _____
- Heart murmur _____
- Anemia _____
- Recurrent ear infections _____
- Hearing problems _____
- Vision or eye problems _____
- Urinary tract infections _____
- Stomach or digestive problems _____
- Seasonal allergies or eczema _____
- Seizures _____
- Broken bone(s) _____
- Learning disability _____
- Other chronic medical problems _____

Has your child ever been hospitalized?

- No Yes Why? _____

Previous surgeries: _____

Please list any specialists, including counselors, your child is currently seeing and reason: _____

Developmental

Do you have concerns about any of the following:

- The way your child uses his/her arms, fingers or legs
- Speech problems
- Vision (Are you concerned about your child's vision?)
- Hearing (Are you concerned about your child's hearing?)

Puberty

Concerns about:

- Body changes
- Sexual activity
- Sexually transmitted infection
- Discharge: vaginal or penis
- Contraception

For Girls:

Age of first menstrual period? _____

Social Emotional/Stress Indicators

Does your child have problems with:

- Depression/ anxiety _____
- ADD/ADHD _____
- School attendance
- Getting along with other children including siblings
- Getting along with parents or other adults
- Problems with sleeping or nightmares
- Bad temper/breath holding/jealousy
- Nail biting/thumb sucking
- Bedwetting (after 6 years)
- Threaten to harm self, others or animals
- Sexual acting out
- Destroying property
- Drug use, alcohol use or smoking

Exposure Risks

- Passive smoke Cigarettes E-Cigs Chew
- Alcohol Other drugs _____
- Access to weapons Has a weapon(s)
- Excessive television/video game/internet/cell phone use
- Hours per day: _____ Who supervises usage? _____
- Wears protective gear, including seat belts? Yes No
- Any concerns about lead exposure (old home, plumbing, peeling paint)? Yes No

Medications

Current medications and dose: _____

Vitamins: _____

Herbs/home remedies: _____

Over the counter: _____

Allergies/reactions to medications or vaccines: _____

Nutrition

- Has your child had any dietary problems? _____
- Unexplained weight gain
- Unexplained weight loss
- Food allergies: _____

Dental

- Problems with teeth or gums
- Bad breath
- Has your child been seen by a dentist? Yes No
- If so, date of last exam: _____
- Why did he/she see the dentist? _____

Family Medical History

Do any family members have any of the following conditions?

Condition	Mother	Father	Sibling	Grandparent
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression/anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug and alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnosed Mental Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____				

Other Concerns/Issues:

Reviewed by: _____

Date: _____

West Virginia Department of Health and Human Resources
EPSDT/HealthCheck Program
Preventive Health Screen

Name: _____ DOB: _____ PAGE 2

Additional Documentation

Date: _____ Interperiodic Screen
Check box if this is an encounter outside of the defined periodicity for this child

100% Enteral Foods Yes No
If enteral foods, attach registered dietitian evaluation, most recent history and physical exam (H&P), height and weight, swallowing evaluation and labs.

Medical Necessity Form

It is the responsibility of the ordering healthcare provider to complete this medical necessity form and provide adequate documentation or information of the plan of treatment. The healthcare provider then gives this information either to the patient or directly to the treatment provider. The treatment provider must be enrolled in West Virginia Medicaid.

A. Patient's Medical ID Number: _____

B.

ICD-10 Code(s)	Clinical Diagnosis

C.

Item or Service Prescription	Length of need (# of months)	Amt/Mo Requested

D. Clinical Indication(s) for Item(s)/Service(s) Requested:

E. Provider Certification

I certify that I have examined the member as part of an EPSDT periodic or interperiodic screen and the services requested are part of the plan of care. They are reasonable, medically necessary, and cost effective, and are not convenience items for the member or any individual involved with the member's care. I certify that the member or his/her representative has been offered a choice of vendors.

Print Provider / Clinic Name *Provider Signature*

Medicaid ID Number *Date*

Official Use Only:

Screen Date _____

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

1 Day-4 Week Month Form

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ HC _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

History: No change Initial screen
Birth weight _____ Discharge weight _____
Newborn metabolic screen NL
Newborn critical congenital heart disease pulse oximetry _____
Newborn hearing screen Pass Fail
Concerns and questions:

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

Social Emotional Health/Interpersonal Trauma¹

Social/Family: Check those that apply
Adjustment to new child _____

Parent(s)/Caretaker(s) working outside home? Yes No
Child care plans? _____
Sibling(s) in the home? Yes No _____
Reaction of sibling(s) to new child? NA

Social Emotional/Stress Indicators: Check those that apply
Is there stress in the home? Yes No

Who do you call for help? _____

Risk Indicators: Check those that apply
Exposure to: Passive Smoke Cigarettes E-Cigs
 Chew Alcohol Other drugs _____
Are there weapon(s) in the home? Yes No
Are the weapon(s) secured? Yes No NA
Do you utilize a car seat for your child? Yes No

Developmental

Developmental Surveillance: Check those that apply
Gross Motor: Raises head slightly in prone position
 Flexed posture Moves all extremities
Sensory: Blinks in reaction to bright light
 Follows with eyes, fixates on human face
 Responds to sound Can be consoled when crying

Physical Health

Current Health Indicators: Check those that apply
 No change
Changes since last visit:

Do you think your child sees okay? Yes No

Do you think your child hears okay? Yes No

Oral Health Screen: Check those that apply
Water source: Public Well Tested
 Current oral health problems _____

Nutrition: Check those that apply
 Breast feeding; Frequency _____
 Bottle feeding; Amount _____ Frequency _____
 Formula _____

Normal elimination _____
 Normal sleep patterns _____
 Sleeps 3-4 hours at a time _____
 Can stay awake for 1 hour or longer _____
Concerns: _____

See Periodicity Schedule for risk indicators
Tuberculosis Risk (at 4 weeks): Low risk High risk

Physical Examination: = Normal limits

General Appearance Skin
 Neurological Reflexes
 Head Fontanelles Neck
 Eyes Red Reflex Ears
 Nose Oral Cavity/Throat
 Lung Heart Pulses
 Abdomen Genitalia Back
 Hips Extremities

Jaundice Yes No
Possible Signs of Abuse Yes No

Health Education:
 Discussed Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, injury and violence prevention, infant care, illness prevention, promotion of parent-infant interaction, family relationships, and community interaction

Risk indicators reviewed/screen complete
Assessment: Well Child Other Diagnosis

Immunizations: Attach current immunization record
 UTD Given, see vaccine record

Labs:
Referrals: Developmental Other
 RFTS BTT CSHCN 1-800-642-9704

Prior Authorizations:
For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: _____

Please Print Name of Facility or Clinician

Signature of Clinician/Title

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Screen Date _____

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

2 Month Form

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ HC _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

History: No change
Newborn metabolic screen NL
Concerns and questions:

Follow up on previous concerns:

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

Social Emotional Health/Interpersonal Trauma¹

Social/Family: Check those that apply

Family situation change No change

Has your child lived anywhere but with parent(s)/caretaker(s)?

Yes No _____

Parent(s)/Caretaker(s) working outside home? Yes No

Child care? Yes No _____

Ability to separate from parent(s)/caretaker(s)? Yes No

Sibling(s) in the home? Yes No _____

Social Emotional/Stress Indicators: Check those that apply

Is there stress in the home? Yes No

Who do you call for help? _____

Risk Indicators: Check those that apply

Exposure to: Passive Smoke Cigarettes E-Cigs

Chew Alcohol Other drugs _____

Are there weapon(s) in the home? Yes No

Are the weapon(s) secured? Yes No NA

Do you utilize a car seat for your child? Yes No

Developmental

Developmental Surveillance: Check those that apply

Gross Motor: Lifts head when prone

Holds head erect for periods when held upright

Grasps objects

Sensory: Responds to sounds, attentive to voices

Follows objects with eyes, shows interest

Communication: Coos

Different cries for different needs

Social: Social smile, smiles responsively

Shows pleasure in interactions with adults

Physical Health

Current Health Indicators: Check those that apply

No change

Changes since last visit:

Do you think your child sees okay? Yes No

Do you think your child hears okay? Yes No

Oral Health Screen: Check those that apply

Water source: Public Well Tested

Current oral health problems _____

Nutrition: Check those that apply

Breast feeding; Frequency _____

Bottle feeding; Amount _____ Frequency _____

Formula _____

Vitamins _____

Normal elimination _____

Normal Sleep patterns _____

Physical Examination: = Normal limits

General Appearance Skin

Neurological Reflexes

Head Fontanelles Neck

Eyes Red Reflex Ocular Alignment

Ears Nose

Oral Cavity/Throat Lung

Heart Pulses Abdomen

Genitalia Back Hips

Extremities

Possible Signs of Abuse Yes No

Health Education:

Discussed Handout(s) given

Healthy and safe habits: nutrition, sleep, oral/dental care, injury and violence prevention, infant care, illness prevention, promotion of parent-infant interaction, family relationships, and community interaction

Risk indicators reviewed/screen complete

Assessment: Well Child Other Diagnosis

Immunizations: Attach current immunization record

UTD Given, see vaccine record

Labs:

Referrals: Developmental Other

RFTS BTT CSHCN 1-800-642-9704

Prior Authorizations:

For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: 4 months of age Other

Please Print Name of Facility or Clinician

Signature of Clinician/Title

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Screen Date _____

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

4 Month Form

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ HC _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

History: No change
Newborn metabolic screen NL
Concerns and questions:

Follow up on previous concerns:

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

Social Emotional Health/Interpersonal Trauma¹

Social/Family: Check those that apply

Family situation change No change

Has your child lived anywhere but with parent(s)/caretaker(s)?
 Yes No _____

Parent(s)/Caretaker(s) working outside home? Yes No

Child care? Yes No _____

Ability to separate from parent(s)/caretaker(s)? Yes No

Sibling(s) in the home? Yes No _____

Social Emotional/Stress Indicators: Check those that apply

Is there stress in the home? Yes No

Who do you call for help? _____

Risk Indicators: Check those that apply

Exposure to: Passive Smoke Cigarettes E-Cigs

Chew Alcohol Other drugs _____

Are there weapon(s) in the home? Yes No

Are the weapon(s) secured? Yes No NA

Do you utilize a car seat for your child? Yes No

Developmental

Developmental Surveillance: Check those that apply

Gross Motor: Holds head erect

Raises body on hands with head up Rolls front to back

Fine Motor: Reaches for and grabs objects

Brings hands together Begins to bat at objects

Sensory: Responds to sounds Follows objects with eyes

Looks at and may become excited by mobile

Recognizes parent's voice and touch

Communication: Coos

Blows bubbles, makes "raspberry sounds"

Social: Social smile Laughs or squeals

Able to comfort self (e.g., falls asleep without breast or bottle)

Physical Health

Current Health Indicators: Check those that apply

No change

Changes since last visit:

Do you think your child sees okay? Yes No

Do you think your child hears okay? Yes No

Oral Health Screen: Check those that apply

Water source: Public Well Tested

Current oral health problems _____

Nutrition: Check those that apply

Breast feeding; Frequency _____

Bottle feeding; Amount _____ Frequency _____

Formula _____

Juice Water

Has started solid foods Normal eating habits

Vitamins _____

Normal elimination _____

Sleep patterns _____

See Periodicity Schedule for risk indicators

Hemoglobin/Hematocrit Risk: Low risk High risk

Physical Examination: = Normal limits

General Appearance

Skin

Neurological

Reflexes

Head

Fontanelles

Neck

Eyes

Red Reflex

Ocular Alignment

Ears

Nose

Oral Cavity/Throat

Lung

Heart

Pulses

Abdomen

Genitalia

Back

Hips

Extremities

Possible Signs of Abuse Yes No

Health Education:

Discussed

Handout(s) given

Healthy and safe habits: nutrition, sleep, oral/dental care, injury and violence prevention, infant care, illness prevention, promotion of parent-infant interaction, family relationships, and community interaction

Risk indicators reviewed/screen complete

Assessment: Well Child Other Diagnosis

Immunizations: Attach current immunization record

UTD

Given, see vaccine record

Labs:

Referrals: Developmental Other

RFTS BTT CSHCN 1-800-642-9704

Prior Authorizations:

For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: 6 months of age Other

Please Print Name of Facility or Clinician _____

Signature of Clinician/Title _____

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Screen Date _____

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

6 Month Form

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ HC _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

History: No change
Newborn metabolic screen NL
Concerns and questions:

Follow up on previous concerns:

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

Social Emotional Health/Interpersonal Trauma¹

Social/Family: Check those that apply

Family situation change No change

Has your child lived anywhere but with parent(s)/caretaker(s)?

Yes No _____

Parent(s)/Caretaker(s) working outside home? Yes No

Child care? Yes No _____

Ability to separate from parent(s)/caretaker(s)? Yes No

Sibling(s) in the home? Yes No _____

Social Emotional/Stress Indicators: Check those that apply

Is there stress in the home? Yes No

Who do you call for help? _____

Risk Indicators: Check those that apply

Exposure to: Passive Smoke Cigarettes E-Cigs

Chew Alcohol Other drugs _____

Are there weapon(s) in the home? Yes No

Are the weapon(s) secured? Yes No NA

Do you utilize a car seat for your child? Yes No

Developmental

Developmental Surveillance: Check those that apply

Gross Motor: Sits with support Rolls over

Stands when placed and bears weight

Fine Motor: Transfers objects from hand to hand

Starts to self-feed; grasps and mouths objects

Rakes in small objects

Communication: Vocalizes single consonants (“dada,” “baba”)

Babbles, laughs and squeals Plays by making sounds

Shows interest in toys

Social: Social smile Shows pleasure

Shows differential recognition of parents

May begin to show signs of stranger anxiety Self comforts

Physical Health

Current Health Indicators: Check those that apply

No change

Changes since last visit:

Do you think your child sees okay? Yes No

Do you think your child hears okay? Yes No

Oral Health Screen: Check those that apply

Water source: Public Well Tested

Current oral health problems _____

Nutrition: Check those that apply

Breast feeding; Frequency _____

Bottle feeding; Amount _____ Frequency _____

Formula _____

Juice Water

Has started solid foods Normal eating habits

Vitamins _____

Normal elimination _____

Sleep patterns _____

See Periodicity Schedule for risk indicators

Tuberculosis Risk: Low risk High risk

Lead Risk: Low risk High risk

Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?

Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?

Has a sibling or playmate who has or did have lead poisoning?

Physical Examination: = Normal limits

General Appearance

Skin

Neurological

Reflexes

Head

Fontanelles

Neck

Eyes

Red Reflex

Ocular Alignment

Ears

Nose

Oral Cavity/Throat

Lung

Heart

Pulses

Abdomen

Genitalia

Back

Hips

Extremities

Possible Signs of Abuse Yes No

Health Education:

Discussed

Handout(s) given

Healthy and safe habits: nutrition, sleep, oral/dental care, injury and violence prevention, infant care, illness prevention, promotion of parent-infant interaction, family relationships, and community interaction

Risk indicators reviewed/screen complete

Assessment: Well Child

Other Diagnosis

Immunizations: **Attach current immunization record**

UTD Given, see vaccine record

Labs: Blood lead, if high risk

Referrals: Developmental Blood lead 10_>ug/dl Other

RFTS BTT CSHCN 1-800-642-9704

Prior Authorizations:

For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: 9 months of age Other

Please Print Name of Facility or Clinician

Signature of Clinician/Title

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Screen Date _____

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

9 Month Form

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ HC _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

History: No change
Concerns and questions:

Follow up on previous concerns:

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

Social Emotional Health/Interpersonal Trauma¹

Social/Family: **Check those that apply**

Family situation change No change

Has your child lived anywhere but with parent(s)/caretaker(s)?

Yes No _____

Parent(s)/Caretaker(s) working outside home? Yes No

Child care? Yes No _____

Ability to separate from parent(s)/caretaker(s)? Yes No

Sibling(s) in the home? Yes No _____

Social Emotional/Stress Indicators: **Check those that apply**

Is there stress in the home? Yes No

Who do you call for help? _____

Risk Indicators: **Check those that apply**

Exposure to: Passive Smoke Cigarettes E-Cigs

Chew Alcohol Other drugs _____

Are there weapon(s) in the home? Yes No

Are the weapon(s) secured? Yes No NA

Do you utilize a car seat for your child? Yes No

Developmental

Developmental Surveillance & Screening completed

Standardized Screening Tool:

ASQ3 Other: _____

Results in chart/record Yes No

Physical Health

Current Health Indicators: **Check those that apply**

No change

Changes since last visit:

Do you think your child sees okay? Yes No

Do you think your child hears okay? Yes No

Oral Health Screen: **Check those that apply**

Water source: Public Well Tested

Tooth eruption

Current oral health problems _____

Nutrition: **Check those that apply**

Breast feeding; Frequency _____

Bottle feeding; Amount _____ Frequency _____

Formula _____

Milk Juice Water

Has started solid foods Normal eating habits

Vitamins _____

Normal elimination _____

Normal sleep patterns _____

Lead Risk: Low risk High risk

Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?

Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?

Has a sibling or playmate who has or did have lead poisoning?

Physical Examination: = **Normal limits**

General Appearance

Skin

Neurological

Reflexes

Head

Fontanelles

Neck

Eyes

Red Reflex

Ocular Alignment

Ears

Nose

Oral Cavity/Throat

Lung

Heart

Pulses

Abdomen

Genitalia

Back

Hips

Extremities

Possible Signs of Abuse Yes No

Health Education:

Discussed

Handout(s) given

Healthy and safe habits: nutrition, sleep, oral/dental care, injury and violence prevention, infant care, illness prevention, promotion of parent-infant interaction, family relationships, and community interaction

Risk indicators reviewed/screen complete

Assessment: Well Child Other Diagnosis

Immunizations: Attach current immunization record

UTD Given, see vaccine record

Labs: Blood lead, if high risk

Referrals: Developmental Blood lead 10_≥ug/dl Other

RFTS BTT CSHCN 1-800-642-9704

Prior Authorizations:

For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: 12 months of age Other

Please Print Name of Facility or Clinician

Signature of Clinician/Title

¹ Some responses may indicate adverse childhood experiences. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. For assistance phone 844-HELP4WV (844-435-7498).

Screen Date _____

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ HC _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

History: No change
Concerns and questions:

Follow up on previous concerns:

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

Social Emotional Health/Interpersonal Trauma¹

Social/Family: Check those that apply
 Family situation change No change

Has your child lived anywhere but with parent(s)/caretaker(s)?
 Yes No _____

Parent(s)/Caretaker(s) working outside home? Yes No

Child care? Yes No _____

Ability to separate from parent(s)/caretaker(s)? Yes No
Sibling(s) in the home? Yes No _____

Social Emotional/Stress Indicators: Check those that apply
Is there stress in the home? Yes No

Who do you call for help? _____

Risk Indicators: Check those that apply

Exposure to: Passive Smoke Cigarettes E-Cigs

Chew Alcohol Other drugs

Are there weapon(s) in the home? Yes No

Are the weapon(s) secured? Yes No NA

Do you utilize a car seat for your child? Yes No

Developmental

Developmental Surveillance: Check those that apply

Gross Motor: Pulls self to standing Crawls

Walks with support

Fine Motor: Feeds self with fingers, drinks from cup

Pincer grasp Bangs two blocks together

Communication: Uses 1- 2 words

Imitates vocalizations and sounds* Babbling*

Social: Protodeclarative pointing*

Social smile Waves bye-bye

Peekaboo Looks at pictures

Patty-cake Looks for dropped or hidden objects

*Absence of these milestones=Autism Screen

Physical Health

Current Health Indicators: Check those that apply

No change

Changes since last visit:

Do you think your child sees okay? Yes No

Do you think your child hears okay? Yes No

Oral Health Screen: Check those that apply

Water source: Public Well Tested

Fluoride Yes No

Tooth eruption

Current oral health problems _____

Dental referral required at 12 months

Nutrition: Check those that apply

Breast feeding; Frequency _____

Bottle feeding; Amount _____ Frequency _____

Formula _____

Milk Juice Water

Has started solid foods Normal eating habits

Vitamins _____

Normal elimination _____

Normal sleep patterns _____

See Periodicity Schedule for risk indicators

Tuberculosis Risk: Low risk High risk

Lead Risk: Blood lead required at 12 months

Hemoglobin/Hematocrit Risk: HGB/HCT required at 12 months

Physical Examination: = Normal limits

General Appearance

Skin

Neurological

Reflexes

Head

Fontanelles

Neck

Eyes

Red Reflex

Ocular Alignment

Ears

Nose

Oral Cavity/Throat

Lung

Heart

Pulses

Abdomen

Genitalia

Back

Hips

Extremities

Possible Signs of Abuse Yes No

Health Education:

Discussed

Handout(s) given

Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, family relationships, and community interaction

Risk indicators reviewed/screen complete

Assessment: Well Child Other Diagnosis

Immunizations: Attach current immunization record

UTD Given, see vaccine record

Labs: HGB/HCT required at 12 months

Blood lead required at 12 months

Referrals: Developmental Dentist Blood lead 10₂ug/dl

Other BTT CSHCN 1-800-642-9704

Prior Authorizations:

For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: 15 months of age Other

Please Print Name of Facility or Clinician

Signature of Clinician/Title

¹ Some responses may indicate adverse childhood experiences. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. For assistance phone 844-HELP4WV (844-435-7498).

Screen Date _____

15 Month Form

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ HC _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

History: No change
Concerns and questions:

Follow up on previous concerns:

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

Social Emotional Health/Interpersonal Trauma¹

Social/Family: Check those that apply
 Family situation change No change

Has your child lived anywhere but with parent(s)/caretaker(s)?
 Yes No _____
Parent(s)/Caretaker(s) working outside home? Yes No
Child care? Yes No _____
Ability to separate from parent(s)/caretaker(s)? Yes No
Sibling(s) in the home? Yes No _____

Social Emotional/Stress Indicators: Check those that apply
Is there stress in the home? Yes No

Who do you call for help? _____

Risk Indicators: Check those that apply

Exposure to: Passive Smoke Cigarettes E-Cigs
 Chew Alcohol Other drugs

Are there weapon(s) in the home? Yes No
Are the weapon(s) secured? Yes No NA
Do you utilize a car seat for your child? Yes No

Developmental

Developmental Surveillance: Check those that apply

Gross Motor: Walks well, stoops, climbs stairs

Fine Motor: Feeds self with fingers, drinks from cup
 Scribbles Stacks 2 blocks

Communication: Uses 1 word* Uses 3-10 words
 Indicates what he/she wants by pulling, pointing or grunting
 Understands simple commands Points to pictures in book

Social: Gives and takes food or toys Throws objects in play
 Listens to a story

*Absence of these milestones=Autism Screen

Physical Health

Current Health Indicators: Check those that apply

No change
Changes since last visit:

Do you think your child sees okay? Yes No

Do you think your child hears okay? Yes No

Oral Health Screen: Check those that apply

Date of last dental visit _____
Water source: Public Well Tested
Fluoride Yes No
 Current oral health problems? _____

Nutrition: Check those that apply

Breast feeding; Frequency _____
 Bottle feeding; Amount _____ Frequency _____
 Formula _____
 Milk Juice Water Normal eating habits
 Vitamins _____
 Normal elimination _____
 Normal sleep patterns _____

See Periodicity Schedule for risk indicators

Hemoglobin/Hematocrit Risk: Low risk High risk

Tuberculosis Risk: Low risk High risk

Lead Risk: Low risk High risk

Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
 Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?

Has a sibling or playmate who has or did have lead poisoning?

Physical Examination: = Normal limits

General Appearance Skin
 Neurological Reflexes
 Head Fontanelles Neck
 Eyes Red Reflex Ocular Alignment
 Ears Nose
 Oral Cavity/Throat Lung
 Heart Pulses Abdomen
 Genitalia Back Hips
 Extremities

Possible Signs of Abuse Yes No

Health Education:

Discussed Handout(s) given

Healthy and safe habits: nutrition, sleep, oral/dental care, injury and violence prevention, social competence, family relationships, and community interaction

Risk indicators reviewed/screen complete

Assessment: Well Child Other Diagnosis

Immunizations: Attach current immunization record

UTD Given, see vaccine record

Labs: Blood lead, if high risk

Referrals: Developmental Dentist Blood lead 10_≥ug/dl
 Other BTT CSHCN 1-800-642-9704

Prior Authorizations:

For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: 18 months of age Other

Please Print Name of Facility or Clinician

Signature of Clinician/Title

¹ Some responses may indicate adverse childhood experiences. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. For assistance phone 844-HELP4WV (844-435-7498).

Screen Date _____

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ HC _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

History: No change
Concerns and questions:

Follow up on previous concerns:

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

Social Emotional Health/Interpersonal Trauma¹

Social/Family: Check those that apply

Family situation change No change

Has your child lived anywhere but with parent(s)/caretaker(s)?

Yes No _____

Parent(s)/Caretaker(s) working outside home? Yes No

Child care? Yes No _____

Ability to separate from parent(s)/caretaker(s)? Yes No

Sibling(s) in the home? Yes No _____

Social Emotional/Stress Indicators: Check those that apply

Is there stress in the home? Yes No

Who do you call for help? _____

Risk Indicators: Check those that apply

Exposure to: Passive Smoke Cigarettes E-Cigs

Chew Alcohol Other drugs _____

Are there weapon(s) in the home? Yes No

Are the weapon(s) secured? Yes No NA

Do you utilize a car seat for your child? Yes No

Developmental

Developmental Surveillance & Screening completed:

Standardized Screening Tool:

ASQ3 Other: _____

Results in chart/record Yes No

Autism Screening completed:

Autism Specific Screening Tool:

M-CHAT Other: _____

Results in chart/record Yes No

Physical Health

Current Health Indicators: Check those that apply

No change

Changes since last visit:

Do you think your child sees okay? Yes No

Do you think your child hears okay? Yes No

Oral Health Screen: Check those that apply

Date of last dental visit: _____

Water source: Public Well Tested

Fluoride Yes No

Current oral health problems: _____

Nutrition: Check those that apply

Breast feeding; Frequency _____

Bottle feeding; Amount _____ Frequency _____

Formula _____

Milk Juice Water Normal eating habits

Vitamins _____

Normal elimination _____

Normal sleep patterns _____

See Periodicity Schedule for risk indicators

Hemoglobin/Hematocrit Risk: Low risk High risk

Tuberculosis Risk: Low risk High risk

Lead Risk: Low risk High risk

Lives in or regularly visits a house/child care facility

built before 1970 or that has been recently remodeled?

Lives near a heavily traveled highway or battery

recycling plant or lives with an adult whose job or hobby

involves exposure to lead?

Has a sibling or playmate who has or did have lead

poisoning?

Physical Examination: = Normal limits

General Appearance

Skin

Neurological

Reflexes

Head

Fontanelles

Neck

Eyes

Red Reflex

Ocular Alignment

Ears

Nose

Oral Cavity/Throat

Lung

Heart

Pulses

Abdomen

Genitalia

Back

Hips

Extremities

Possible Signs of Abuse Yes No

Health Education:

Discussed

Handout(s) given

Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, family relationships, and community interaction

Risk indicators reviewed/screen complete

Assessment: Well Child

Other Diagnosis

Immunizations: Attach current immunization record

UTD Given, see vaccine record

Labs: Blood lead level, if high risk

Referrals: Developmental Dentist Blood lead 10_≥ug/dl

Other BTT CSHCN 1-800-642-9704

Prior Authorizations:

For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: 24 months of age Other

Please Print Name of Facility or Clinician

Signature of Clinician/Title

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Screen Date _____

24 Month Form

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ BMI _____ HC _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

History: No change
Concerns and questions:

Follow up on previous concerns:

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

Social Emotional Health/Interpersonal Trauma¹

Social/Family: Check those that apply

Family situation change No change

Has your child lived anywhere but with parent(s)/caretaker(s)?

Yes No _____

Parent(s)/Caretaker(s) working outside home? Yes No

Child care? Yes No _____

Ability to separate from parent(s)/caretaker(s)? Yes No

Sibling(s) in the home? Yes No _____

Gets along with other family members? Yes No

Social Emotional/Stress Indicators: Check those that apply

Is there stress in the home? Yes No

Who do you call for help? _____

Has your child ever had a really scary or bad experience that they cannot forget? Yes No

Does your child have bad dreams or nightmares? Yes No

Has your child experienced an emotional loss? Yes No

Risk Indicators: Check those that apply

Exposure to: Passive Smoke Cigarettes E-Cigs

Chew Alcohol Other drugs _____

Are there weapon(s) in the home? Yes No

Are the weapon(s) secured? Yes No NA

Do you utilize a car seat for your child? Yes No

Excessive television/video game/internet/cell phone use

Hours per day: _____ Who supervises usage? _____

Developmental

Developmental Surveillance: Check those that apply

Gross Motor: Runs Walk up and down stairs

Kicks ball Throws ball

Fine Motor: Uses spoon and fork Opens a door

Makes horizontal and circular strokes with crayon

Stacks 5-6 blocks

Communication: Uses 2 word phrases ≥20 word vocabulary

Follows two-step commands Uses pronouns

Listens to stories

Cognitive: Hides and finds objects Pretend plays

Problem solves

Social: Parallel play with other children Imitates adults

Autism Screening completed:

Autism Specific Screening Tool:

M-CHAT Other: _____

Results in chart/record Yes No

Physical Health

Current Health Indicators: Check those that apply

No change

Changes since last visit:

Do you think your child sees okay? Yes No

Do you think your child hears okay? Yes No

Oral Health Screen: Check those that apply

Date of last dental visit: _____

Water source: Public Well Tested

Fluoride Yes No

Current oral health issues _____

Nutrition: Check those that apply

Normal eating habits _____

Vitamins _____

Normal elimination Normal sleep patterns

Lead Risk: Blood lead required at 24 months

See Periodicity Schedule for risk indicators

Hemoglobin/Hematocrit Risk: Low risk High risk

Dyslipidemia Risk: Low risk High risk

Tuberculosis Risk: Low risk High risk

Physical Examination: = Normal limits

General Appearance

Skin

Neurological

Reflexes

Head

Neck

Eyes

Red Reflex

Ocular Alignment

Ears

Nose

Oral Cavity/Throat

Lung

Heart

Pulses

Abdomen

Genitalia

Back

Hips

Extremities

Possible Signs of Abuse Yes No

Health Education:

Discussed

Handout(s) given

Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, family relationships, and community interaction

Risk indicators reviewed/screen complete

Assessment: Well Child

Other Diagnosis

Immunizations: Attach current immunization record

UTD Given, see vaccine record

Labs: Blood lead level required at 24 months

Referrals: Developmental Emotional Dentist

Blood lead 10>ug/dl Other

BTT CSHCN 1-800-642-9704

Birth To Three transition planning

Prior Authorizations:

For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: 30 months of age Other

Please Print Name of Facility or Clinician

Signature of Clinician/Title

¹ Some responses may indicate adverse childhood experiences. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. For assistance phone 844-HELP4WV (844-435-7498).

Screen Date _____

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

30 Month Form

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ BMI _____ HC _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

History: No change
Concerns and questions:

Follow up on previous concerns:

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

Social Emotional Health/Interpersonal Trauma¹

Social/Family: Check those that apply

Family situation change No change

Has your child lived anywhere but with parent(s)/caretaker(s)?

Yes No _____

Parent(s)/Caretaker(s) working outside home? Yes No

Child care? Yes No _____

Ability to separate from parent(s)/caretaker(s)? Yes No

Sibling(s) in the home? Yes No _____

Gets along with other family members? Yes No

Social Emotional/Stress Indicators: Check those that apply

Is there stress in the home? Yes No

Who do you call for help? _____

Has your child ever had a really scary or bad experience that they cannot forget? Yes No

Does your child have bad dreams or nightmares? Yes No

Has your child experienced an emotional loss? Yes No

Risk Indicators: Check those that apply

Exposure to: Passive Smoke Cigarettes E-Cigs

Chew Alcohol Other drugs _____

Are there weapon(s) in the home? Yes No

Are the weapon(s) secured? Yes No NA

Do you utilize a car seat for your child? Yes No

Excessive television/video game/internet/cell phone use

Hours per day: _____ Who supervises usage? _____

Developmental

Developmental Surveillance & Screening completed: Standardized Screening Tool:

ASQ3 Other: _____

Results in chart/record Yes No

Comments: _____

Physical Health

Current Health Indicators: Check those that apply

No change

Changes since last visit:

Do you think your child sees okay? Yes No

Do you think your child hears okay? Yes No

Oral Health Screen: Check those that apply

Date of last dental visit _____

Water source: Public Well Tested

Fluoride Yes No

Current oral health issues _____

Nutrition: Check those that apply

Normal eating habits _____

Vitamins _____

Normal elimination Normal sleep patterns

Lead Risk: Low risk High risk

Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?

Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?

Has a sibling or playmate who has or did have lead

See Periodicity Schedule for risk indicators

Hemoglobin/Hematocrit Risk: Low risk High risk

Tuberculosis Risk: Low risk High risk

Physical Examination: = Normal limits

General Appearance

Neurological

Neck

Ocular Alignment

Oral Cavity/Throat

Pulse

Back

Reflexes

Eyes

Ears

Lung

Abdomen

Hips

Skin

Head

Red Reflex

Nose

Heart

Genitalia

Extremities

Possible Signs of Abuse Yes No

Health Education:

Discussed

Handout(s) given

Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, family relationships, and community interaction

Risk indicators reviewed/screen complete

Assessment: Well Child

Other Diagnosis

Immunizations: Attach current immunization record

UTD Given, see vaccine record

Labs:

Referrals: Developmental Emotional Dentist

Blood lead 10_>ug/dl Other

BTT CSHCN 1-800-642-9704

Birth To Three transition planning

Prior Authorizations:

For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: 3 years of age Other

Please Print Name of Facility or Clinician

Signature of Clinician/Title

¹ Some responses may indicate adverse childhood experiences. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. For assistance phone 844-HELP4WV (844-435-7498).

Screen Date _____

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ BMI _____ BP _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

Health conditions that may require care at school _____

Vision Acuity Screen (obj) R _____ L _____
 Unable to obtain, re-screen in 4-6 month
 Wears glasses Yes No

Hearing Screen (Subjective screen required at 3)
 Do you think your child hears okay? Yes No
 Wears hearing aids Yes No

Oral Health Screen
 Date of last dental visit _____
 Water source: Public Well Tested
 Fluoride Yes No
 Current oral health problems: _____

Developmental

Developmental Surveillance: Check those that apply
Gross Motor: Jumps in place Kicks ball Rides tricycle
 Up/down stairs alternating feet
Fine Motor: Uses cup, spoon and fork Has manual dexterity
 Builds a tower with 6 or 8 cubes Copies a circle
Communication: Speaks intelligibly
 Uses 3-4 word sentences Short paragraphs
 Uses plurals and pronouns
Cognitive: Follows 2 step instructions
 Aware of gender (of self and others)
 Knows name, age and sex Names most common objects
Social: Listens to stories Shows early imaginative behavior
 Plays interactive games with peers (able to take turns)

Immunizations: Attach current immunization record
 UTD Given, see vaccine record

Referrals: Developmental Emotional Dentist Vision
 Hearing Blood lead 10≥ug/dl CSHCN 1-800-642-9704

Provider signature required for validation
 Risk indicators reviewed/screen complete

Please Print Name of Facility or Clinic

Signature of Clinician/Title

The information above this line is intended to be released to meet school entry requirements.

School Entry Requirements



History: No change
 Concerns and questions: _____

Follow up on previous concerns: _____

Recent injuries, illnesses, visits to other providers or counselors and/or hospitalizations: _____

Risk Indicators: Check those that apply
 Exposure to: Passive Smoke Cigarettes E-Cigs Chew
 Alcohol Other drugs _____
 Are there weapon(s) in the home? Yes No
 Are the weapon(s) secured? Yes No NA
 Do you utilize a car/booster seat for your child? Yes No
 Excessive television/video game/internet/cell phone use
 Hours per day: _____ Who supervises usage? _____
 Pre-school Yes No
 Attends school regularly _____ NA
 Special classes _____ NA
 Participates in extracurricular activities _____

See Periodicity Schedule for risk indicators
Hemoglobin/Hematocrit Risk: Low risk High risk
Tuberculosis Risk: Low risk High risk

Physical Examination: = Normal limits
 General Appearance Skin
 Neurological Reflexes
 Head Neck
 Eyes Red Reflex Ocular Alignment
 Nose Ears Oral Cavity/Throat
 Lungs Heart Pulses
 Abdomen Genitalia
 Back Extremities

Social Emotional Health/Interpersonal Trauma¹

Social/Family: Check those that apply
 Family situation change No change

Has your child lived anywhere but with parent(s)/caretaker(s)?
 Yes No _____
 Parent(s)/Caretaker(s) working outside home? Yes No
 Child care? Yes No _____
 Ability to separate from parent(s)/caretaker(s)? Yes No
 Sibling(s) in the home? Yes No _____
 Gets along with other family members? Yes No

Physical Health

Current Health Indicators: Check those that apply
 No change
 Changes since last visit: _____

Health Education:
 Discussed Handout(s) given
 Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, school entry, family relationships, and community interaction

Assessment: Well Child Other Diagnosis

Labs: Blood lead, if needed or high risk

Referrals: (see above) Other

Prior Authorizations:
 For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: 4 years of age Other

Social Emotional/Stress Indicators: Check those that apply
 Is there stress in the home? Yes No

Has your child ever had a really scary or bad experience that they cannot forget? Yes No _____
 Does your child have bad dreams or nightmares? Yes No

Has your child experienced an emotional loss? Yes No

¹ Some responses may indicate adverse childhood experiences. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. For assistance phone 844-HELP4WV (844-435-7498).

Screen Date _____

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ BMI _____ BP _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

Health conditions that may require care at school _____

Vision Acuity Screen (obj) R _____ L _____
 Unable to obtain, re-screen in 4-6 month
Wears glasses Yes No

Hearing Screen (obj)
25 db@ _____ 20 db@ _____
R ear: _____ 500HZ R ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
L ear: _____ 500HZ L ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
Wears hearing aids Yes No

Oral Health Screen
Date of last dental visit _____
Water source: Public Well Tested
Fluoride Yes No
 Current oral health problems:

History: No change
Concerns and questions:

Follow up on previous concerns:

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

Social Emotional Health/Interpersonal Trauma¹

Social/Family: Check those that apply
 Family situation change No change

Has your child lived anywhere but with parent(s)/caretaker(s)?
 Yes No _____

Parent(s)/Caretaker(s) working outside home? Yes No

Child care? Yes No _____

Ability to separate from parent(s)/caretaker(s)? Yes No

Sibling(s) in the home? Yes No _____

Gets along with other family members? Yes No

Social Emotional/Stress Indicators: Check those that apply
Is there stress in the home? Yes No

Has your child ever had a really scary or bad experience that they cannot forget? Yes No _____

Does your child have bad dreams or nightmares? Yes No

Has your child experienced an emotional loss? Yes No

Developmental

Developmental Surveillance: Check those that apply
Gross Motor: Walks, climbs, runs Hops, jumps on 1 foot
 Up/down stairs alternating feet, without support
 Throws overhand Rides bicycle with training wheels
Fine Motor: Builds 10 block tower Uses utensils
 Has manual dexterity Draws 3 part person
 Puts on/removes clothes
Communication: Uses past tense Talks about daily experiences
 Speaks intelligibly Uses 4-5 word sentences
 Short paragraphs May show some lack of fluency
Cognitive: Names 4 colors Aware of gender (self and others)
 Knows difference between fantasy and reality
Social: Listens to stories Can sing a song
 Plays interactive games with peers Elaborate fantasy play

Risk Indicators: Check those that apply
Exposure to: Passive Smoke Cigarettes E-Cigs Chew
 Alcohol Other drugs
 Access to weapon(s) Has a weapon(s)
Do you utilize a car/booster seat for your child Yes No
 Excessive television/video game/internet/cell phone use
Hours per day: _____ Who supervises usage? _____

Pre-school Yes No
 Attends school regularly _____ NA
 Special classes _____ NA
 Participates in extracurricular activities _____

Physical Health

Current Health Indicators: Check those that apply
 No change
Changes since last visit:

Nutrition: Normal eating habits Vitamins _____
 Normal elimination Normal sleep patterns

Lead Risk: Low risk High risk
 Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
 Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
 Has a sibling or playmate who has or did have lead poisoning?

Immunizations: Attach current immunization record
 UTD Given, see vaccine record

Referrals: Developmental Emotional Dentist Vision
 Hearing Blood lead 10 \geq ug/dl CSHCN 1-800-642-9704

Provider signature required for validation
 Risk indicators reviewed/screen complete

Please Print Name of Facility or Clinic

Signature of Clinician/Title

The information above this line is intended to be released to meet school entry requirements.

See Periodicity Schedule for risk indicators
Hemoglobin/Hematocrit Risk: Low risk High risk
Dyslipidemia Risk: Low risk High risk
Tuberculosis Risk: Low risk High risk

Physical Examination: = Normal limits
 General Appearance Skin
 Neurological Reflexes
 Head Neck
 Eyes Red Reflex Ocular Alignment
 Nose Ears Oral Cavity/Throat
 Lungs Heart Pulses
 Abdomen Genitalia
Possible Signs of Abuse Yes No

Health Education:
 Discussed Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, school entry, family relationships, and community interaction

Assessment: Well Child Other Diagnosis

Labs: Blood lead, if needed or high risk

Referrals: see above Other

Prior Authorizations:
For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: 5 years of age Other

School Entry Requirements



¹ Some responses may indicate adverse childhood experiences. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. For assistance phone 844-HELP4WV (844-435-7498).

Screen Date _____

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

5 Year Form

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ BMI _____ BP _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

Health conditions that may require care at school _____

Vision Acuity Screen (obj) R _____ L _____
Wears glasses Yes No

Hearing Screen (obj)
25 db@ _____ 20 db@ _____
R ear: _____ 500HZ R ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
L ear: _____ 500HZ L ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
Wears hearing aids Yes No

Oral Health Screen
Date of last dental visit _____
Water source: Public Well Tested
Fluoride Yes No
 Current oral health problems: _____

Developmental

Developmental Surveillance: *Check those that apply*
Gross Motor: Walks, climbs, runs May be able to skip
 Up/down stairs alternating feet, without support
Fine Motor: Copies ▲ or ■ Prints some letters
 Draws figure w/head, arms and legs Dresses self
 Has manual dexterity
Communication: Able to recall parts of story Fluent speech
 Uses complete sentences Speaks in short sentences
 Uses future tense Second language spoken at home
Cognitive: Knows address and phone # Can count on fingers
 Follows 2-3 step instructions
 Recognizes many letters of the alphabet
Social: Listens to stories Follows rules
 Plays interactive games with peers
 Elaborate fantasy play/make believe/dress up

Immunizations: Attach current immunization record
 UTD Given, see vaccine record

Referrals: Developmental Emotional Dentist Vision
 Hearing Blood lead 10 ≥ ug/dl CSHCN 1-800-642-9704

Provider signature required for validation
 Risk indicators reviewed/screen complete

Please Print Name of Facility or Clinic

Signature of Clinician/Title

The information above this line is intended to be released to meet school entry requirements.

School Entry Requirements

History: No change
Concerns and questions:
Follow up on previous concerns:

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

Social Emotional Health/Interpersonal Trauma¹

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

Has your child lived anywhere but with parent(s)/caretaker(s)?
 Yes No _____

Parent(s)/Caretaker(s) working outside home? Yes No
Child care? Yes No _____

Ability to separate from parent(s)/caretaker(s)? Yes No
Sibling(s) in the home? Yes No _____

Gets along with other family members? Yes No

Social Emotional/Stress Indicators: *Check those that apply*
Is there stress in the home? Yes No

Has your child ever had a really scary or bad experience that they cannot forget? Yes No _____

Does your child have bad dreams or nightmares? Yes No

Has your child experienced an emotional loss? Yes No

Risk Indicators: *Check those that apply*

Exposure to: Passive Smoke Cigarettes E-Cigs Chew
 Alcohol Other drugs _____

Access to weapon(s) Has a weapon(s)
Do you wear protective gear, including seat belts? Yes No
 Excessive television/video game/internet/cell phone use

Hours per day: _____ Who supervises usage? _____
 Pre-school School/Grade _____

Attends school regularly _____
 Special classes _____

Participates in extracurricular activities _____

Physical Health

Current Health Indicators: *Check those that apply*

No change
Changes since last visit:

Nutrition: Normal eating habits Vitamins _____

Normal elimination Normal sleep patterns

Lead Risk: Low risk High risk
 Lives in or regularly visits a house/child care facility built before 1970 or that has been recently remodeled?
 Lives near a heavily traveled highway or battery recycling plant or lives with an adult whose job or hobby involves exposure to lead?
 Has a sibling or playmate who has or did have lead poisoning?

See Periodicity Schedule for risk indicators
Hemoglobin/Hematocrit Risk: Low risk High risk
Tuberculosis Risk: Low risk High risk

Physical Examination: = Normal limits

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

Possible Signs of Abuse Yes No

Health Education:
 Discussed Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, sexuality, injury and violence prevention, social competence, school entry, family relationships, and community interaction

Assessment: Well Child Other Diagnosis

Labs: Blood lead, if needed or high risk

Referrals: (see above) Other

Prior Authorizations:
For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: 6 years of age Other

¹ Some responses may indicate adverse childhood experiences. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. For assistance phone 844-HELP4WV (844-435-7498).

Screen Date _____

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

6 Year Form

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ BMI _____ BP _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

Health conditions that may require care at school _____

Vision Acuity Screen (obj) R _____ L _____
Wears glasses Yes No

Hearing Screen (obj)
25 db@ _____ 20 db@ _____
R ear: _____ 500HZ R ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
L ear: _____ 500HZ L ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
Wears hearing aids Yes No

Oral Health Screen
Date of last dental visit _____
Water source: Public Well Tested
Fluoride Yes No
 Current oral health problems:

History: No change
Concerns and questions:
Follow up on previous concerns:
Recent injuries, illnesses, visits to other providers or counselors
and/or hospitalizations:

Social Emotional Health/Interpersonal Trauma¹
Social/Family: Check those that apply
 Family situation change No change

Have you lived anywhere but with parent(s)/caretaker(s)?
 Yes No _____
Parent(s)/Caretaker(s) working outside home? Yes No
Child care? Yes No _____
Ability to separate from parent(s)/caretaker(s)? Yes No
Sibling(s) in the home? Yes No _____
Do you get along with other family members? Yes No

Social Emotional/Stress Indicators: Check those that apply
Friend(s): _____ Yes No
Fun activities: _____
Feelings: Okay/content Sad Angry Down/depressed
 Poor self image Experienced an emotional loss
Thoughts/plans to harm Self Others Animals NA
Have you ever had a really scary or bad experience that you
cannot forget? Yes No _____
Do you have bad dreams or nightmares? Yes No

Has anyone ever hit, choked, kicked or hurt you? Yes No

Do your friends ever ask you to do things you don't want to do?
 Yes No _____
Has anyone ever touched you where your bathing suit goes or
made you touch them when you did not want to? Yes No

Developmental

Developmental Surveillance: Check those that apply
Gross Motor: Backwards tandem walk
 Balances on each foot with eyes closed-smooth transition
Fine Motor: Ties shoes Draws picture of family
Communication: Fluent speech Uses complete sentences
Cognitive: Knows name and address
 Knows emergency phone number Prints name
 Prints alphabet
Social: Anger control Follows rules

Immunizations: Attach current immunization record
 UTD Given, see vaccine record

Risk Indicators: Check those that apply
 Lack of physical activity Weight or height concerns
Exposure to: Passive Smoke Cigarettes E-Cigs Chew
 Alcohol Other drugs _____
 Access to weapon(s) Has a weapon(s)
Do you wear protective gear, including seat belts? Yes No
 Excessive television/video game/internet/cell phone use
Hours per day: _____ Who supervises usage? _____
School/Grade _____ Attends school regularly
 Special classes _____
 Trouble at school _____
 Participates in extracurricular activities _____

Sex education
 Sex education/questions

Physical Health
Current Health Indicators: Check those that apply
 No change
Changes since last visit:

Nutrition: Normal eating habits Vitamins _____
 Normal elimination Normal sleep patterns

Lead Risk: Low risk High risk
 Lives in or regularly visits a house/child care facility
built before 1970 or that has been recently remodeled?
 Lives near a heavily traveled highway or battery
recycling plant or lives with an adult whose job or hobby
involves exposure to lead?
 Has a sibling or playmate who has or did have lead
poisoning?

Referrals: Developmental Emotional Dentist Vision
 Hearing Blood lead 10_≥ug/dl CSHCN 1-800-642-9704

Provider signature required for validation
 Risk indicators reviewed/screen complete

Please Print Name of Facility or Clinic

Signature of Clinician/Title

*The information above this line is intended to be released to
meet school entry requirements.*

See Periodicity Schedule for risk indicators
Hemoglobin/Hematocrit Risk: Low risk High risk
Dyslipidemia Risk: Low risk High risk
Tuberculosis Risk: Low risk High risk

Physical Examination: = Normal limits
 General Appearance Skin
 Neurological Reflexes
 Head Neck
 Eye Ocular Alignment
 Nose Ears Oral Cavity/Throat
 Lungs Heart Pulses
 Abdomen Genitalia
 Back Extremities
Possible Signs of Abuse Yes No

Health Education:
 Discussed Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care,
sexuality, injury and violence prevention, social competence, school
entry, family relationships, and community interaction

Assessment: Well Child Other Diagnosis

Labs: Blood lead, if needed or high risk

Referrals: (see above) Other

Prior Authorizations:
For treatment plans requiring authorization, please complete
page 2 on the reverse. Contact a HealthCheck Regional Program
Specialist for assistance at 1-800-642-9704 or
www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: 7 years of age Other

School Entry Requirements



¹ Some responses may indicate adverse childhood experiences. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. For assistance phone 844-HELP4WV (844-435-7498).

Screen Date _____

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

7 and 8 Year Form

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ BMI _____ BP _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

Health conditions that may require care at school _____

Immunizations: Attach current immunization record
 UTD Given, see vaccine record

 Vision Acuity Screen (Obj @ 8 yrs) R _____ L _____
Wears glasses Yes No

 Hearing Screen (Obj @ 8 yrs)
as indicated by risk screen: 20 db@
R ear: _____ 500HZ R ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
L ear: _____ 500HZ L ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
Wears hearing aids Yes No

Oral Health Screen
Date of last dental visit _____
Water source: Public Well Tested
Fluoride Yes No
 Current oral health problems:

 Developmental Surveillance

Referrals: Behavioral/Mental Health Dentist Vision
 Hearing CSHCN 1-800-642-9704

Provider signature required for validation
 Risk indicators reviewed/screen complete

Please Print Name of Facility or Clinic _____

Signature of Clinician/Title _____

The information above this line is intended to be released to meet school entry requirements.

School Entry Requirements

History: No change
Concerns and questions:

Follow up on previous concerns:

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

Has anyone ever hit, choked, kicked or hurt you? Yes No

Do your friends ever ask you to do things you don't want to do?
 Yes No

Has anyone ever touched you where your bathing suit goes or made you touch them when you did not want to? Yes No

Nutrition: Check those that apply
 Normal eating habits _____
 Vitamins: _____
 Normal elimination Normal sleep patterns

Social Emotional Health/Interpersonal Trauma¹

Social/Family: Check those that apply
 Family situation change No change

Have you lived anywhere but with parent(s)/caretaker(s)?
 Yes No
Parent(s)/Caretaker(s) working outside home? Yes No
Child care? Yes No
Sibling(s) in the home? Yes No
Do you get along with other family members? Yes No
If you could, how would you change your life?
home? _____
family? _____

Risk Indicators: Check those that apply
 Lack of physical activity Weight or height concerns
Exposure to: Passive Smoke Cigarettes E-Cigs Chew
 Alcohol Other drugs
 Access to weapon(s) Has a weapon(s) Trouble with the law
Do you wear protective gear, including seat belts? Yes No
 Excessive television/video game/internet/cell phone use
Hours per day: _____ Who supervises usage? _____
School/Grade _____
 Attends school regularly
How are you doing in school? _____
 Math at grade level Reads at grade level
 Special classes
 Trouble at school
 Participates in extracurricular activities _____

See Periodicity Schedule for risk indicators
Hemoglobin/Hematocrit Risk: Low risk High risk
Dyslipidemia Risk: Low risk High risk
Tuberculosis Risk: Low risk High risk

Social Emotional/Stress Indicators: Check those that apply
Friend(s): Yes No
Fun activities: _____
Feelings: Okay/content
 Angry Less than a week More than a week
 Down/depressed Less than a week More than a week
 Poor self image Experienced an emotional loss
Thoughts/plans to harm Self Others Animals NA
Have you ever had a really scary or bad experience that you cannot forget? Yes No
Do you have bad dreams or nightmares? Yes No

Sex education
 Sex education/questions

Physical Examination: Normal limits
 General Appearance Skin Neurological
 Reflexes Head Neck
 Eyes Ears Nose
 Oral Cavity/Throat Lungs Heart
 Pulses Abdomen Genitalia
 Back Extremities
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

Assessment: Well Child Other Diagnosis

Lab's:

Referrals*: (see above) Other
*** See Provider Manual for automatic referrals**

Prior Authorizations:
For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

¹ Some responses may indicate adverse childhood experiences and may require further evaluation. Adverse childhood experiences are potentially traumatic events that can have negative, lasting effects on health and well-being. These experiences range from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. For assistance phone 844-HELP4WV (844-435-7498).

Follow Up/Next Visit: 8 years of age
 9 years of age Other

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ BMI _____ BP _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

History: No change
Concerns and questions:

Follow up on previous concerns:

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

Social Emotional Health/Interpersonal Trauma

Social/Family: Check those that apply

Family situation: No change

Parent(s)/Caretaker(s) working outside home? Yes No

Child care? Yes No

Have you lived anywhere but with your parents/caregivers?

Yes No _____

Sibling(s) in the home? Yes No _____

Do you get along with other family members? Yes No

If you could, how would you change your life?
home? _____

family? _____

Traumatic Stress Reactions¹: Check one for each question

Feelings over the past 2 weeks:

Repeated, disturbing memories, thoughts, or images of a stressful experience from the past? Not at all

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

A little bit (1) Moderately (2) Quite a bit (3)
 Extremely (4)

Psychosocial/Behavior Screen: Check those that apply

Friend(s): Yes No

Fun activities: _____

Feelings: Okay/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 NA

Experienced an emotional loss

Risk indicators: Check those that apply

None identified Poor self image

Lack of physical activity Weight or height concerns

Tobacco use: Cigarettes/# per day _____
 E-Cigs Chew Passive Smoking Risk
 *Alcohol use _____ *Other drugs _____

***If positive see Periodicity Schedule**

Access to weapon(s) Has a weapon(s)

Witnessed violence Threatened with violence

Trouble with the law

Peer pressure to do things you don't want to do:

Has anyone ever hit, choked, kicked or hurt you? Yes No

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

Excessive television/video game/internet/cell phone use

School/Grade _____

Attends school regularly

How are you doing in school? _____

Math at grade level Reads at grade level

Special classes _____

Trouble at school _____

Participates in extracurricular activities _____

Sex education: Check those that apply

Has anyone ever touched you in a sexual way or made you touch them when you did not want to? Yes No

Sex education/questions

Physical Health

Current Health Indicators: Check those that apply

No change LMP _____ NA

Changes since last visit:

Nutrition: Check those that apply

Normal eating habits

Vitamins: _____

Normal elimination

Normal sleep patterns

See Periodicity Schedule for risk indicators

Hemoglobin/Hematocrit Risk: Low risk High risk

Dyslipidemia Risk: Low risk High risk

Tuberculosis Risk: Low risk High risk

Vision Acuity Screen (Obj @ 10 yrs) R _____ L _____

Hearing Screen (Obj @ 10 yrs)

as indicated by risk screen: 25db @

R ear: _____ 500HZ _____ 1000HZ _____ 2000HZ _____ 4000HZ

L ear: _____ 500HZ _____ 1000HZ _____ 2000HZ _____ 4000HZ

Oral Health Screen: Check those that apply

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

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

Risk indicators reviewed/screen complete

Assessment: Well Child Other Diagnosis

Immunizations: UTD Given, see vaccine record

Labs: Fasting Lipoprotein Profile (once in late adolescence)

Referrals*: Behavioral/Mental Health Dentist Vision

Hearing Other

CSHCN 1-800-642-9704

*See Provider Manual for automatic referrals

Prior Authorizations:

For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

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

Other

Please Print Name of Facility or Clinician

Signature of Clinician/Title

¹Lang, AG., Stein, M.B. (2005) An abbreviated PTSD checklist for use as a screening instrument in primary care. *Behaviour Research and Therapy*, 43, 585-594. Lang, A. J., Wilkins, K., Roy-Byrne, P. P., Gotlib, D., Chavira, D., Sherbourne, C., Rose, R. D., Bystritsky, A., Sullivan, G., Craske, M. G., & Stein, M. B. (2012). Abbreviated PTSD Checklist (PCL) as a Guide to Clinical Response. *General Hospital Psychiatry*, 34, 332-338. Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility. Paper presented at Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX. An individual is considered to have screened positive if the sum of the numbered responses is 4 or greater. For assistance phone 844-HELP4WV (844-435-7498).

Screen Date _____

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ BMI _____ BP _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

Health conditions that may require care at school _____

Immunizations: Attach current immunization record
 UTD Given, see vaccine record
 Vision Acuity Screen (Obj @ 12 yrs) R _____ L _____
Wears glasses Yes No
 Hearing Screen as indicated by risk screen: 20 db@
R ear: _____ 500HZ R ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
L ear: _____ 500HZ L ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
Wears hearing aids Yes No

Oral Health Screen
Date of last dental visit _____
 Current oral health problems:
 Developmental Surveillance
Referrals: Behavioral/Mental Health Dentist Vision
 Hearing FP CSHCN 1-800-642-9704

Provider signature required for validation
 Risk indicators reviewed/screen complete
Please Print Name of Facility or Clinic _____
Signature of Clinician/Title _____
The information above this line is intended to be released to meet school entry requirements.

School Entry Requirements

History: No change
Concerns and questions:
Follow up on previous concerns:
Recent injuries, illnesses, visits to other providers or counselors and/or hospitalizations:

Psychosocial/Behavior Screen: Check those that apply
Fun activities:
Friend(s): Yes No
 Thoughts/plans to harm Self Others Animals NA
 Experienced an emotional loss

Changes since last visit:
Nutrition:
 Normal eating habits _____
 Vitamins: _____
 Normal elimination Normal sleep patterns

Social Emotional Health/Interpersonal Trauma
Social/Family: Check those that apply
Family situation: No change
Parent(s)/Caretaker(s) working outside home? Yes No
Child care? Yes No NA
Have you lived anywhere but with your parents/caregivers?
 Yes No _____
Sibling(s) in the home? Yes No _____
Do you get along with other family members? Yes No
If you could, how would you change your life?
home? _____
family? _____

Risk indicators: Check those that apply
 None identified Poor self image
 Lack of physical activity Weight or height concerns
 Tobacco use: Cigarettes/# per day _____
 E-Cigs Chew Passive Smoking Risk
 *Alcohol use _____ *Other drugs _____
*If positive see Periodicity Schedule
 Access to weapon(s) Has a weapon(s)
 Witnessed violence Threatened with violence
Has anyone ever hit, choked, kicked or hurt you? Yes No
Have you ever been in jail? Yes No
Do you wear protective gear, including seat belts? Yes No
 Excessive television/video game/internet/cell phone use
School/Grade _____
 Attends school regularly
How are you doing in school?
 Special classes _____
 Trouble at school _____
 Participates in extracurricular activities _____

See Periodicity Schedule for risk indicators
Hemoglobin/Hematocrit Risk: Low risk High risk
Dyslipidemia Risk: Low risk High risk
Tuberculosis Risk: Low risk High risk
Physical Examination: = Normal limits
 General Appearance Skin Neurological
 Reflexes Head Neck
 Eyes Ears Nose
 Oral Cavity/Throat Lungs Heart
 Pulses Abdomen Genitalia
 Back Extremities
Possible Signs of Abuse Yes No

Traumatic Stress Reactions¹: Check one for each question
Feelings over the past 2 weeks:
Repeated, disturbing memories, thoughts, or images of a stressful experience from the past? Not at all
 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
 A little bit (1) Moderately (2) Quite a bit (3)
 Extremely (4)

Relationship/Sex education: Check those that apply
Has anyone ever touched you in a sexual way or made you touch them when you did not want to? Yes No
Are you in a relationship? _____ Male _____ Female
Do you feel safe in your relationship? Yes No
Pressure to have sex Yes No
Sexually Active? Yes No
Method of contraception _____ NA
Do you have any children? Yes No _____
*STI/HIV screening _____ NA
*If positive see Periodicity Schedule

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, school achievement, family relationships, community interaction
Assessment: Well Child Other Diagnosis
Labs:
Referrals*: (see above) Other
* See Provider Manual for automatic referrals

Depression Screen: Check one for each question
If Positive see Periodicity Schedule
Feelings over the past 2 weeks:
Little interest or pleasure in doing things: Not at all
 Several days More than 1/2 the days Nearly every day
Feeling down, depressed, or hopeless: Not at all
 Several days More than 1/2 the days Nearly every day

Physical Health
Current Health Indicators: Check those that apply
 No change LMP _____ NA

Prior Authorizations:
For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck
Follow Up/Next Visit: 12 years of age 13 years of age
 14 years of age Other

¹Lang, AG., Stein, M.B. (2005) An abbreviated PTSD checklist for use as a screening instrument in primary care. Behaviour Research and Therapy, 43, 585-594. Lang, A. J., Wilkins, K., Roy-Byrne, P. P., Golinelli, D., Chavira, D., Sherbourne, C., Rose, R. D., Bystritsky, A., Sullivan, G., Craske, M. G., & Stein, M. B. (2012). Abbreviated PTSD Checklist (PCL) as a Guide to Clinical Response. General Hospital Psychiatry, 34, 332-338. Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility. Paper presented at Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.
An individual is considered to have screened positive if the sum of the numbered responses is 4 or greater. For assistance phone 844-HELP4WV (844-435-7498).

Screen Date _____

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

14, 15, 16 and 17 Year Form

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ BMI _____ BP _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

Health conditions that may require care at school _____

Immunizations: Attach current immunization record
 UTD Given, see vaccine record

 Vision Acuity Screen (Obj @ 15 yrs) R _____ L _____
Wears glasses Yes No

 Hearing Screen as indicated by risk screen: 20 db@
R ear: _____ 500HZ R ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
L ear: _____ 500HZ L ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
Wears hearing aids Yes No

Oral Health Screen
Date of last dental visit _____
 Current oral health problems:

 Developmental Surveillance

Referrals: Behavioral/Mental Health Dentist Vision Hearing
 FP CSHCN 1-800-642-9704

Provider signature required for validation
 Risk indicators reviewed/screen complete

Please Print Name of Facility or Clinic _____

Signature of Clinician/Title _____
The information above this line is intended to be released to meet school entry requirements.

School Entry Requirements

History: No change
Concerns and questions:

Follow up on previous concerns:

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

Psychosocial/Behavior Screen: Check those that apply
Fun activities: _____
Friend(s): Yes No
 Thoughts/plans to harm Self Others Animals NA
 Experienced an emotional loss

Risk indicators: Check those that apply
 None identified Poor self image
 Lack of physical activity Weight or height concerns
 Tobacco use: Cigarettes/# per day _____
 E-Cigs Chew Passive Smoking Risk
 *Alcohol use _____ *Other drugs _____
***If positive see Periodicity Schedule**
 Access to weapon(s) Has a weapon(s)
 Witnessed violence Threatened with violence
Has anyone ever hit, choked, kicked or hurt you? Yes No
Have you ever been in jail? Yes No
Do you wear protective gear, including seat belts? Yes No
 Excessive television/video game/internet/cell phone use
School/Grade _____
 Attends school regularly
How are you doing in school? _____
 Special classes
 Trouble at school _____
 Participates in extracurricular activities _____
Career goals _____
 Working Satisfied with job

Changes since last visit:

Nutrition:
 Normal eating habits _____
 Vitamins: _____
 Normal elimination Normal sleep patterns

See Periodicity Schedule for risk indicators
Hemoglobin/Hematocrit Risk: Low risk High risk
Dyslipidemia Risk: Low risk High risk
Tuberculosis Risk: Low risk High risk

Social Emotional Health/Interpersonal Trauma
Social/Family: Check those that apply
Family situation: No change
Parent(s)/Caretaker(s) working outside home? Yes No
Child care? Yes No NA
Have you lived anywhere but with your parents/caregivers?
 Yes No _____
Sibling(s) in the home? Yes No _____
Do you get along with other family members? Yes No
If you could, how would you change your life?
home? _____
family? _____

Traumatic Stress Reactions¹: Check one for each question
Feelings over the past 2 weeks:
Repeated, disturbing memories, thoughts, or images of a stressful experience from the past? Not at all
 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
 A little bit (1) Moderately (2) Quite a bit (3)
 Extremely (4)

Depression Screen: Check one for each question
If Positive see Periodicity Schedule
Feelings over the past 2 weeks:
Little interest or pleasure in doing things: Not at all
 Several days More than 1/2 the days Nearly every day
Feeling down, depressed, or hopeless: Not at all
 Several days More than 1/2 the days Nearly every day

Physical Examination: = Normal limits
 General Appearance Skin Neurological
 Reflexes Head Neck
 Eyes Ears Nose
 Oral Cavity/Throat Lungs Heart
 Pulses Abdomen Genitalia
 Back Extremities
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, school achievement, family relationships, community interaction, and health care transition from adolescence to adulthood in the medical home

Assessment: Well Child Other Diagnosis

Lab's:

Referrals*: (see above) Other
*** See Provider Manual for automatic referrals**

Prior Authorizations:
For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Relationship/Sex education: Check those that apply
Has anyone ever touched you in a sexual way or made you touch them when you did not want to? Yes No
Are you in a relationship? _____ Male _____ Female
Do you feel safe in your relationship? Yes No
Pressure to have sex Yes No
Sexually Active? Yes No
Method of contraception _____ NA
Do you have any children? Yes No _____
*STI/HIV screening _____ NA
***If positive see Periodicity Schedule**

Physical Health
Current Health Indicators: Check those that apply
 No change LMP _____ NA

Follow Up/Next Visit: 15 years of age 16 years of age
 17 years of age 18 years of age Other

Screen Date _____

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

18, 19 and 20 Year Form

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ BMI _____ BP _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Self Other _____

History: No change
Concerns and questions:

Follow up on previous concerns:

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

Social Emotional Health/Interpersonal Trauma

Social/Family: Check those that apply

Family situation: No change
Parent(s)/Caretaker(s) working outside home? Yes No
Child care? Yes No NA
Have you lived anywhere but with your parents/caregivers?
 Yes No _____
Sibling(s) in the home? Yes No _____
Do you get along with other family members? Yes No
If you could, how would you change your life?
home? _____
family? _____

Traumatic Stress Reactions¹: Check one for each question

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

Depression Screen: Check one for each question

If Positive see Periodicity Schedule
Feelings over the past 2 weeks:
Little interest or pleasure in doing things: Not at all
 Several days More than 1/2 the days Nearly every day
Feeling down, depressed, or hopeless: Not at all
 Several days More than 1/2 the days Nearly every day

Psychosocial/Behavior Screen: Check those that apply

Fun activities: _____
Friend(s): Yes No
 Thoughts/plans to harm Self Others Animals NA
 Experienced an emotional loss

Risk indicators: Check those that apply

None identified Poor self image
 Lack of physical activity Weight or height concerns
 Tobacco use: Cigarettes/# per day _____
 E-Cigs Chew Passive Smoking Risk
 *Alcohol use _____ *Other drugs _____
***If positive see Periodicity Schedule**
 Access to weapon(s) Has a weapon(s)
 Witnessed violence Threatened with violence
Has anyone ever hit, choked, kicked or hurt you? Yes No
Have you ever been in jail? Yes No
Do you wear protective gear, including seat belts? Yes No
 Excessive television/video game/internet/cell phone use
School/Vocational Grade _____ NA
 Attends school regularly Trouble at school
How are you doing in school? _____
 Special classes _____
 Participates in extracurricular activities _____
Career goals _____
 Working Satisfied with job

Relationship/Sex education: Check those that apply

Has anyone ever touched you in a sexual way or made you touch them when you did not want to? Yes No
Are you in a relationship? _____ Male _____ Female
Do you feel safe in your relationship? Yes No
Pressure to have sex Yes No
Sexually active? Yes No
Method of contraception _____ NA
Do you have any children? Yes No _____
*STI/HIV screening _____ NA
***If positive see Periodicity Schedule**

Physical Health

Current Health Indicators: Check those that apply

No change LMP _____ NA

Changes since last visit:

Nutrition: Normal eating habits
 Vitamins: _____

Normal elimination Normal sleep patterns

See Periodicity Schedule for risk indicators

Hemoglobin/Hematocrit Risk: Low risk High risk

Dyslipidemia Risk: Low risk High risk

Tuberculosis Risk: Low risk High risk

Vision Acuity Screen: (Obj @ 18 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 _____

Physical Examination: = Normal limits

General Appearance Skin Neurological
 Reflexes Head Neck
 Eyes Ears Nose
 Oral Cavity/Throat Lungs Heart
 Pulses Abdomen Genitalia
 Back Extremities
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, school vocational achievement, family relationships, community interaction, and health care transition from adolescence to adulthood in the medical home

Risk indicators reviewed/screen complete
Assessment: Well Child Other Diagnosis

Immunizations: UTD Given, see vaccine record

Labs: Fasting Lipoprotein Profile (once in late adolescence)

Referrals*: Behavioral/Mental Health Dentist Vision
 Hearing Other
 CSHCN FP 1-800-642-9704

*See Provider Manual for automatic referrals

Prior Authorizations:

For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck

Follow Up/Next Visit: 19 years of age 20 years of age
 Other

Please Print Name of Facility or Clinician

Signature of Clinician/Title

¹Lang, AG., Stein, M.B. (2005) An abbreviated PTSD checklist for use as a screening instrument in primary care. *Behaviour Research and Therapy*, 43, 585-594. Lang, A. J., Wilkins, K., Roy-Byrne, P. P., Golinelli, D., Chavira, D., Sherbourne, C., Rose, R. D., Bystritsky, A., Sullivan, G., Craske, M. G., & Stein, M. B. (2012). Abbreviated PTSD Checklist (PCL) as a Guide to Clinical Response. *General Hospital Psychiatry*, 34, 332-338. Weathers, F., Litz, B., Herman, D., Huska, J., & Keane, T. (October 1993). The PTSD Checklist (PCL): Reliability, Validity, and Diagnostic Utility. Paper presented at Annual Convention of the International Society for Traumatic Stress Studies, San Antonio, TX.
An individual is considered to have screened positive if the sum of the numbered responses is 4 or greater. For assistance phone 844-HELP4WV (844-435-7498).