

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 Reactions<sup>1</sup>:  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