

Screen Date _____

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

30 Month Form

Name _____ DOB _____ Age _____ Sex: M F Race/Ethnicity _____

Weight _____ Height _____ BMI _____ Pulse _____ BP _____ Resp _____ Temp _____ Pulse Ox (optional) _____

Allergies NKDA _____

Current meds None _____

Foster child _____ Kinship placement _____ Child with special health care needs _____

Accompanied by Parent Grandparent Foster parent Foster organization _____ Other _____

Medical History

Initial screen Periodic screen

Family health history reviewed _____

In utero substance exposure Yes No _____

Child currently receiving mental/behavioral health services?

Yes No _____

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

Psychosocial/Behavioral

What is your family's living situation? _____

Family relationships Good Okay Poor

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

Who do you contact for help and/or support? _____

Are you and/or your partner working outside home? Yes No

Child care _____

Child has ability to separate from parents/caregivers Yes No

Child exposed to Cigarettes E-Cigarettes/Vaping Alcohol

Drugs (prescription or otherwise) _____

Access to firearm(s)/weapon(s)

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

Witnessed violence/abuse Threatened with violence/abuse

Scary experience that your child cannot forget _____

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

Excessive television/video game/internet/cell phone use

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

None Slight Moderate Severe

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

Relationships (partner, family and/or friends) School/work
 Child care Drugs Alcohol Violence/abuse (physical, emotional and/or sexual) Family member incarcerated Lack of support/help Financial/money Emotional loss Health insurance Other _____

Does your child seem nervous or afraid?

Not at all Somewhat Very much

Does your child seem sad or unhappy?

Not at all Somewhat Very much

Does your child get upset when things are not done a certain way?

Not at all Somewhat Very much

Does your child have a hard time with change?

Not at all Somewhat Very much

Does your child have trouble playing with other children?

Not at all Somewhat Very much

Does your child break things on purpose?

Not at all Somewhat Very much

Does your child have a hard time calming down?

Not at all Somewhat Very much

Is your child aggressive?

Not at all Somewhat Very much

Is it hard to take your child out in public?

Not at all Somewhat Very much

Is it hard to know what your child needs?

Not at all Somewhat Very much

Is it hard to get your child to obey you?

Not at all Somewhat Very much

Developmental

Developmental surveillance and screening completed with Standardized Screening Tool

ASQ3 Other tool _____

Results in child's record Yes No

General Health

Growth plotted on growth chart

Do you think your child sees okay? Yes No

Do you think your child hears okay? Yes No

Oral Health

Date of last dental visit _____

Current oral health problems _____

Water source Public Well Tested

Fluoride supplementation Yes No

Fluoride varnish applied (apply every 3 to 6 months)

Yes No _____

Nutrition/Sleep

Normal eating habits

Fruits/vegetables/lean protein per day _____

Vitamins _____

Normal elimination _____

Toilet trained Yes No

Normal sleeping patterns _____

Hours of sleep each night? _____

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