Screen Date____________________

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

**9 and 10 Year 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____________ ☐ IEP/section 504 in place____________

Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ Foster organization______________________ ☐ Other ____________

## Medical History

☐ Initial Screen ☐ Periodic screen

☐ **Family health history reviewed** ____________________

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

______________________________

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

## Psychosocial/Behavioral

What is your family living situation______________________

Family relationships ☐ Good ☐ Okay ☐ Poor

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

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

Child care/after school care ______________________

Grade in school______________________

Favorite subject______________________

Any problems?______________________

Activities outside school______________________

Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

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

☐ Drugs (prescription or otherwise)____________________

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

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

☐ Witnessed violence/abuse ☐ Threatened with violence/abuse

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

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

Concerns about speech, learning, social or motor skills ____________

Concerns about depression and/or anxiety____________________

**Traumatic Stress Reactions/PCL-C**

***Positive screen = numbered responses 4 or greater***

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

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

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

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

☐ None ☐ Slight ☐ Moderate ☐ Severe

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

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

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

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

- ☐ Talks or repeatedly thinks about harming self, killing self, or wanting to die
- ☐ Frequently mean to other people or animals
- ☐ Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)
- ☐ Behavior frequently typically inappropriate and causes problems for self or others (i.e., fighting, belligerency, promiscuity)
- ☐ Frequent use of profane, vulgar, or curse words to household members
- ☐ Deliberate damage to home
- ☐ Frequently truant (i.e., approximately once every 2 weeks or for several consecutive days)
- ☐ Marked changes in moods that are generally intense and abrupt
- ☐ Friendships change to mostly substance users
- ☐ Preoccupying cognitions or fantasies with bizarre, odd, or gross themes
- ☐ Currently at risk of confinement because of frequent or serious violations of law
- ☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources

## General Health

☐ Growth plotted on growth chart

☐ BMI calculated and plotted on BMI chart

**Nutrition/Physical Activity/Sleep**

Normal eating habits? ☐ Yes ☐ No

Fruits/vegetables/lean protein per day____________________

☐ Vitamins____________________

☐ Normal elimination____________________

☐ Physical activity/exercise an hour most days

Type of physical activity/exercise ____________________

Normal sleeping patterns? ☐ Yes ☐ No

Hours of sleep each night?____________________

**Oral Health**

Date of last dental visit____________________

Current oral health problems ____________________

Water source ☐ Public ☐ Well ☐ Tested

Fluoride supplementation ☐ Yes ☐ No

**Vision Acuity Screen:** *(Objective 10 years)*

R ____________ L ____________

Wears glasses? ☐ Yes ☐ No

**Continue on page 2**

Name______________________________ DOB______________________ Age______________ Sex: ☐ M ☐ F

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

***Anemia Risk** **(Hemoglobin/Hematocrit)** ☐ Low risk ☐ High risk
***Tuberculosis Risk** ☐ Low risk ☐ High risk
***Dyslipidemia Risk** ☐ Low risk ☐ High risk
*Fasting lipoprotein required once between 9 and 11 years*
***Hepatitis B Risk** ☐ Low risk ☐ High risk

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

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

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

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

**Possible Signs of Abuse/Neglect** ☐ Yes ☐ No

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

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

## Questions/Concerns/Notes

________________________________________________
________________________________________________
________________________________________________

## Plan of Care

**Assessment**
☐ Well Child ☐ Other Diagnosis

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

**Labs**
☐ Hemoglobin/hematocrit *(if high risk)*
☐ TB skin test *(if high risk)*
☐ Fasting lipoprotein (*once between 9 and 11 years and/or high risk)*
☐ Hepatitis B Screen (HBsAG) *(if high risk)*
☐ Other ________________________________________
________________________________________________

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

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

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

**Follow Up/Next Visit** ☐ 10 years of age ☐ 11 years of age
☐ Other________________________________________

### ☐ Screen has been reviewed and is complete

________________________________________________
**Please Print Name of Facility or Clinician**

________________________________________________
**Signature of Clinician/Title**

West Virginia Department of HEALTH