EPSDT/HealthCheck Health History Form

0-6 Years

Patient Name:	Date of Birth:			_ Age:	:	
Your Name:						
Child's Health History		ild's Hea	Ith Histo	<u>ry</u>		
Pregnancy and Birth Medical problems during pregnancy?	Medications Current medications and o	dose:				
In utero substance exposure?						
Maternal Hep C exposure?	Vitamins:					
Where was the child born?	Herbs/home remedies:					
Delivered by: ☐ Vaginal ☐ C-section	Over the counter:					
Why C-section?	Allergies/reactions to me	edications	or vaccir	nes:		
Birth Weight: Birth Length:	g					
High Birth Score:						
☐ Full Term (≥ 37 weeks gestation)						
☐ Preterm (≤ 36 weeks gestation)	Nutrition and Feeding					
□ NICU stay: weeks	☐ Has your child had any	feeding/di	etary prob	lems?		
Other problems in the newborn period?						
	Unexplained weight ga					
Infancy and Childhood	 Unexplained weight los 					
Has your child ever been treated for or diagnosed with:	☐ Food allergies:					
Asthma or wheezing	□ Participates in WIC □	Yes 🗆	No			
□ Pneumonia	Dental					
Lung problems	☐ Problems with teeth or	aume				
☐ Heart murmur	☐ Bad breath	guins				
□ Anemia	Has your child been seen	hy a dentic	t2 □ Va	s □ No		
□ Recurrent ear infections						
☐ Hearing problems	If so, date of last exam: _ Why did he/she see the de	antiet?				
☐ Vision or eye problems	Water source: City					
☐ Urinary tract infections	water source. City	□ AACII				
☐ Stomach or digestive problems	<u>Far</u>	nily Medi	cal Histo	ory		
☐ Seasonal allergies or eczema	Do any family members	s have an	v of the fo	ollowina	conditions?	
□ Seizures	Condition	-	Father	_	Grandparent	
☐ Broken bone(s)	Asthma		П			
☐ Learning disability	Anemia		П			
	Blood disorder					
□ Depression/anxiety	Cancer	П	П			
□ ADD/ADHD	Heart disease		П			
☐ Other chronic medical problems	Heart attack					
	High cholesterol					
Has your child ever been hospitalized?	High blood pressure					
□ No □ Yes Why?	Stroke					
Previous surgeries:	Diabetes					
Please list any specialists, including mental/behavioral health providers,	Thyroid disease					
your child is currently seeing and reason:	Kidney disease					
	Seizures					
Developmental	Postpartum depression					
Do you have concerns about any of the following:	Depression/anxiety					
□ Problems with sleeping or nightmares	Diagnosed mental condition					
☐ The way your child uses his/her arms, fingers or legs	Drug and/or alchol use					
• •	Other:		Ш	ш		
☐ Speech problems	Otilei.					
☐ Bad temper/breath holding/jealousy						
☐ Nail biting/thumb sucking	Other Concerns:					
☐ Vision (Are you concerned about your child's vision?)☐ Hearing (Are you concerned about your child's hearing?)	Other Concerns:					
Exposure/Habits						
Any concerns about lead exposure (old home, plumbing,						
peeling paint)?	Reviewed by:					
Do any household members smoke/use tobacco products/e-cigarettes/	Date:					
vaping? ☐ Yes ☐ No			-			
TV hours per day						
Internet/video games hours per day				WEST	/IRGINIA ment of	
Cell phone use hours per day				Depart	ealth.	

☐ Yes ☐ No

Is violence at home a concern?



Patient Name:	Date of Birth:			Age	•
Your Name:					
Child's Health History					
	<u>Chil</u>	d's Heal	th Histor	r <u>y</u>	
Childhood	Medications				
Has your child ever been treated for or diagnosed with:	Current medications and do	se:			
☐ Asthma or wheezing					
□ Pneumonia					
☐ Lung problems					
☐ Heart murmur	Herbs/home remedies:				
□ Recurrent ear infections	Over the counter:				
☐ Hearing problems	Allergies/reactions to med	dications	or vaccin	es:	
□ Vision or eye problems					
☐ Urinary tract infections					
☐ Stomach or digestive problems	Nutrition				
□ Seasonal allergies or eczema	☐ Has your child had any o	lietary nro	hlems?		
□ Seizures	- Tias your crilic flac arry c	iletally pro	DICITIS:		
□ Broken bone(s)	☐ Unexplained weight gair				
☐ Learning disability	☐ Unexplained weight loss				
	☐ Food allergies:				
□ Depression/anxiety					
□ ADD/ADHD	Dental				
☐ Other chronic medical problems:	□ Problems with teeth or g	ums			
	□ Bad breath				
Has your child ever been hospitalized?	Has your child been seen b				s 🗆 No
□ No □ Yes Why?	If so, date of last exam:				
Previous surgeries: Please list any specialists, including mental/behavioral health providers,	Why did he/she see the der	itist?			
your child is currently seeing and reason:	Exposure/Habits Any concerns about lead expeeling paint)? Do any household members			☐ Ye	
Developmental/Behavior	vaping?	SITIONE/U	ise lobacc		s 🗆 No
Do you have concerns about any of the following:	TV hours per day				
□ Problems with sleeping or nightmares	Internet/video games hours				
☐ The way your child uses his/her arms, fingers or legs	Cell phone/social media hor				
□ Speech problems	Is violence at home a conce		<i>,</i>		s 🗆 No
☐ Bad temper/breath holding/jealousy					
□ Nail biting/thumb sucking			cal Histor		
☐ Bedwetting (after 6 years)	Do any family members have	-		-	
☐ Vision (Are you concerned about your child's vision?)	Condition			_	Grandparent
☐ Hearing (Are you concerned about your child's hearing?)	Asthma				
Does your child have problems with:	Anemia				
☐ School attendance	Blood disorder				
☐ Getting along with other children including siblings	Cancer				
☐ Getting along with parents or other adults	Heart disease				
☐ Threaten to harm self, others or animals	Heart attack				
☐ Sexual acting out	High blood proceurs				
☐ Destroying property	High blood pressure Stroke				
☐ Drug use, alcohol use, smoking, e-cigarettes and/or vaping	Diabetes				
Puberty	Thyroid disease				
Concerns about:	Kidney disease				
☐ Body changes	Seizures				
☐ Sexual activity	Depression/anxiety				
☐ Sexually transmitted infection	Diagnosed Mental Condition				
☐ Discharge: vaginal or penis	Drug and/or alchol use				
☐ Contraception	Other				
For Girls:					
Age of first menstrual period?	Other Concerns:				
	Reviewed by:				

Date: ___



Screen Date_		Early and Periodic So			ent of Health and Human Reatment (EPSDT) HealthCheck		eventive Health Scree	Newborn to 1 Week Form
Name					DOB		Age	Sex: 🗆 M 🗆 F
Weight	Length	Weight for Length	_ HC	Pulse	BP (optional)	_ Resp	Temp	Pulse Ox (optional)
Allergies □	NKDA							
Current med	s 🗆 None							
☐ Foster chil	ild		inship placer	ment		☐ Child with	special health care need	s
Accompanie	ed by □ Parent □ G	Grandparent □ Foster parent □ F	oster organiz	zation			□ Other	
Medical Hi	•	od			s □ E-Cigarettes/Vaping □ Alco vise)	Deve	•	(√ Check those that apply)
Concerns and	d/or questions				your family under <u>now</u> ?	wakef	fulness ☐ Child looks at	and studies you when awake
Maternal Hep Gestational a Complication Birth history Birth weight	o C exposure	res □ No	What kind ☐ Relation ☐ Child ca emotional a support/hel	re □ Drugs □ Alcol and/or sexual) □ Fa lp □ Financial/mone		revere that apply) friends) □ School/work fiolence/abuse (physical, mber incarcerated □ Lack of notional loss □ Health picked up □ Child responds differently to soothing to alerting touch Verbal Language □ Child communicates discomford crying, facial expressions and body movements □ C calms to your voice Gross Motor □ Child moves in response to visual o stimuli □ Child moves arms and legs symmetrically a		mmunicates discomfort through body movements
Newborn met Newborn bilir Newborn criti	tabolic screen □ NL rubin screen □ NL ical congenital heart o		□ Not at al Does your □ Not at al	I □ Somewhat □ \ child cry a lot? I □ Somewhat □	y grasps utilets intigers of objects		side nds in fist □ Child automatically	
•	cial/Behavioral family's living situatio	on?	Is it hard to comfort your child? □ Not at all □ Somewhat □ Very Much Is it hard to put your child to sleep? □ Not at all □ Somewhat □ Very much □ Not at all □ Somewhat □ Very much □ Oyou think your child sees ok					
•		to take care of your baby (crib, car			Is it hard to put your child to sleep?		owth plotted on growth ch	
•		ting basic family needs daily and/or	Does your child have trouble staying asleep? Water source: ☐ Public ☐ We ☐ Not at all ☐ Somewhat ☐ Very much		Vell □ Tested			
Who do you	contact for help and/c	or support?				□ Bre	tion/Sleep eastfeeding - Frequency _ ttle feeding - Amount	Frequency

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

Child care plans?

Continue on page 2

☐ Formula _

☐ Normal elimination_

☐ Place on back to sleep___

_			
Screen	Date		

Newborn to 1 Week Form, Page 2

Name		DOB	Age Sex: 🗆 M 🗆 F
Physical Exami	nation (N=Normal, Abn=Abnormal)	Questions/Concerns/Notes	Plan of Care
	e 🗆 N 🗆 Abn		Assessment
Skin	□ N □ Abn		☐ Well Child ☐ Other Diagnosis
Neurological	□ N □ Abn		
Reflexes	□ N □ Abn		
Head	□ N □ Abn		Immunizations
Fontanelles	□ N □ Abn		□ UTD □ Given, see immunization record □ Entered into WVSIIS
Neck	□ N □ Abn		
Eyes	□ N □ Abn		
Red Reflex	□ N □ Abn		Labs
Ears			
Nose	□ N □ Abn		
Oral Cavity/Throat	□ N □ Abn		
Lung	□ N □ Abn		Referrals Developmental
Heart	□ N □ Abn	-	Other
Pulses	□ N □ Abn	-	
Abdomen	□ N □ Abn		☐ Right from the Start (RFTS) 1-800-642-9704
Umbilical cord	□ N □ Abn		☐ Birth to Three (BTT) 1-800-642-9704
Genitalia	□ N □ Abn		☐ Children with Special HealthCare Needs (CSHCN)
Back	□ N □ Abn		1-800-642-9704
Hips			□ Women, Infants and Children (WIC) 1-304-558-0030
Extremities	□ N □ Abn		
Jaundice ☐ Yes ☐			
_	Abuse/Neglect ☐ Yes ☐ No		
Concerns and/or qu	estions	_	Medical Necessity
		_	For treatment plans requiring authorization, please complet
		_	page 3. Contact a HealthCheck Regional Program Specialist fo
		_ 1	assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Age Appropriat	e Health Education/Anticipatory		
Guidance (Consu	ult Bright Futures, Fourth Edition. For further		Follow Up/Next Visit □ 1 month of age □ 2 months of age
information: https://l	brightfutures.aap.org)		Follow Op/Next visit in 1 month of age in 2 months of age
Social Determinants	of Health, Parental/Family Health and		□ Other
Well-Being, Newbor	n Behavior and Care, Nutrition and Feeding,		
and Safety			
□ Discussed	☐ Handouts Given		
			☐ Screen has been reviewed and is complete
		_	
		_	
			Please Print Name of Facility or Clinician
		-	
			Signature of Clinician/Title
			WEST VIRIGINAL Department of

Screen Date Early and Periodic S	West Virginia Departme creening, Diagnosis, and Trea	ent of Health and Human Reso tment (EPSDT) HealthCheck P	urces rogram Preventive He	alth Screen	By 1 Month Form
Name		DOB		Age	Sex: 🗆 M 🗆 F
Weight Length Weight for Length	HC Pulse	BP (optional)	Resp Tem	np Pulse Ox (optional)
Allergies □ NKDA					
Current meds					
□ Foster child □ K				care needs	
Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐ F	oster organization				
Medical History ☐ Initial screen ☐ Periodic screen ☐ Family health history reviewed	How much stress are you and y □ None □ Slight □ Moderate What kind of stress? (✓ Check □ Relationships (partner, family □ Child care □ Drugs □ Alcoh	and/or friends) ☐ School/work	Does your child cry ☐ Not at all (0) ☐ Does your child have	eck one for each question) y a lot? I Somewhat (1) □ Very mucl ive a hard time calming down' I Somewhat (1) □ Very mucl	?
In utero substance exposure	9	nily member incarcerated □ Lack y □ Emotional loss □ Health	of Is your child fussy of □ Not at all (0) □ Is it hard to comfort □ Not at all (0) □	or irritable? I Somewhat (1) □ Very mucl t your child? I Somewhat (1) □ Very mucl	n (2)
Newborn metabolic screen □ NL □ Results in child's record Newborn bilirubin screen □ NL □ Results in child's record Newborn critical congenital heart disease pulse oximetry □ Results in child's record Newborn hearing screen □ Pass □ Fail □ Retest □ Results in child's record Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations: □	Little interest or pleasure in doin	responses 3 or greater hedule for link to Edinburgh EPDS) s: (✓ Check one for each question g things s (1) □ More than ½ the days (2)	Subscale 3 (Subscale 3 (Che Is it hard to keep you Not at all (0) Is it hard to put you Not at all (0) Is it hard to get end Not at all (0) Is it hard to get and Not at all (0)	eck one for each question) our child on a schedule or rou I Somewhat (1)	tine? n (2) n (2) nild?
Psychosocial/Behavioral What is your family's living situation?		s (1) ☐ More than ½ the days (2)	□ Not at all (0) □	Somewhat (1) Uery mucl	n (2)
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No	Baby Pediatric Symptom Chec	cklist (BPSC)	-	 urveillance (✓ Check those th and Self–help □ Child looks	
Who do you contact for help and/or support?	*Positive screen = numbered i	responses 3 or greater in <u>any</u> of lation and/or investigation may	you with his/her eye	res □ Child has self-comfortir to mouth □ Child becomes fu	ng behaviors, such
Are you and/or your partner working outside home? ☐ Yes ☐ No Child care plans?	be needed. Subscale 1 (✓ Check one for each Does your child have a hard time.	ach question) e being with people?	☐ Child calms whe Verbal Language short vowel sounds	ion mount in Child becomes it is in picked up or spoken to (Expressive and Receptive) is in Child alerts to unexpected in the control of the	□ Child makes brief d sounds □ Child

Subscale 1 (✓ Check one for each question)

Does your child have a hard time being with people?

□ Not at all (0) □ Somewhat (1) □ Very much (2)

Does your child have a hard time in new places?

□ Not at all (0) □ Somewhat (1) □ Very much (2)

Does your child have a hard time with change?

□ Not at all (0) □ Somewhat (1) □ Very much (2)

Does your child mind being held by other people?

□ Not at all (0) □ Somewhat (1) □ Very much (2)

Subscale 1 score __

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

Do you have the things you need to take care of your baby (crib, car

☐ Drugs (prescription or otherwise)_

seat, diapers, etc.)? ☐ Yes ☐ No

Verbal Language (Expressive and Receptive) ☐ Child makes brief short vowel sounds ☐ Child alerts to unexpected sounds ☐ Child quiets and turns to your voice ☐ Child shows signs of sensitivity to environment (excessive crying, tremors, excessive startles) ☐ Child has different types of cries for hunger and tiredness Gross Motor ☐ Child moves both arms and legs together

☐ Child can hold chin up when on stomach

Fine Motor $\;\square$ Child can open fingers slightly when at rest



Screen Date			By 1 Month Form, Page 2
Name	DOB	Age	Sex: □M □F

General Health		Signs of Abuse/Neglect ☐ Yes ☐ No	Plan of Care
☐ Growth plotted or	n growth chart		Assessment
Do you think your c	hild sees okay? □ Yes □ No hild hears okay? □ Yes □ No		☐ Well Child ☐ Other Diagnosis
Oral Health Water source:	Public □ Well □ Tested	Age Appropriate Health Education/Anticipatory Guidance (Consult Bright Futures, Fourth Edition. For further	Immunizations □ UTD □ Given, see immunization record □ Entered into WVSIIS
Nutrition/Sleep		information: https://brightfutures.aap.org)	
☐ Breastfeeding - F	Frequency	Social Determinants of Health, Parental/Family Health and	Labs
	Amount Frequency	Well-Being, Infant Behavior and Development, Nutrition and Feeding,	☐ TB skin test (if high risk)
☐ Formula		and Safety □ Discussed □ Handouts Given	□ Other
☐ Normal elimination	on	— d discussed d Handouts Given	
☐ Normal sleeping	patterns		
☐ Place on back to	sleep	Questions/Concerns/Notes	
☐ Sleeps 3 to 4 hou	urs at a time		Referrals ☐ Maternal depression - Help4WV.com/1-844-435-7498
☐ Can stay awake	for 1 hour or longer		□ Developmental
			□ Other
*Tuberculosis Risi			
☐ Low risk ☐ Hig	ıh risk		☐ Right from the Start (RFTS) 1-800-642-9704
			☐ Birth to Three (BTT) 1-800-642-9704
*See Periodicity S	chedule for Risk Factors		☐ Children with Special HealthCare Needs (CSHCN) 1-800-642-9704
			☐ Women, Infants and Children (WIC) 1-304-558-0030
	ination (N=Normal, Abn=Abnormal)		D Women, mand and official (WIO) 1-007-000-000
General Appearance	ce 🗆 N 🗆 Abn		
Skin	□ N □ Abn		Medical Necessity
Neurological	□ N □ Abn		For treatment plans requiring authorization, please complete
Reflexes	□ N □ Abn		page 3. Contact a HealthCheck Regional Program Specialist fo
Head	□ N □ Abn		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Fontanelles	□ N □ Abn		
Neck	□ N □ Abn		
Eyes	□ N □ Abn		Follow Up/Next Visit ☐ 2 months of age
Red Reflex	□ N □ Abn		□ Other
Ears	□ N □ Abn		
Nose	□ N □ Abn		
Oral Cavity/Throat	□ N □ Abn		5 O
Lung	□ N □ Abn		☐ Screen has been reviewed and is complete
Heart	□ N □ Abn		
Pulses	□ N □ Abn		
Abdomen	□ N □ Abn		
Genitalia	□ N □ Abn		Please Print Name of Facility or Clinician
Back	□ N □ Abn		
Hips	□ N □ Abn		
Extremities	□ N □ Abn		
LAUCITIUGS			Signature of Clinician/Title

Sex: □ M □ F

Screen Date Early and Periodic S		nent of Health and Human Resc eatment (EPSDT) HealthCheck P		ive Health Scre	en	2 Month Form
Name		DOB		Ag	e	Sex: □M □F
Weight Length Weight for Length	HC Pulse	BP (optional)	Resp	Temp	Pulse Ox (option	onal)
Allergies □ NKDA	 					
Current meds None				· · · · · · · · · · · · · · · · · · ·	····	
□ Foster child □ Kinship	placement	Child	with special health	care needs		
Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐	Foster organization		□ Oti	ner		
Medical History ☐ Initial screen ☐ Periodic screen ☐ Family health history reviewed	☐ Child care ☐ Drugs ☐ Alco	te □ Sever ck those that apply) ly and/or friends) □ School/work bhol □ Violence/abuse (physical,	Does your on Not at all Does your on Not at all	child have a hard t	at (1) □ Very much (2 time calming down? at (1) □ Very much (2	•
In utero substance exposure ☐ Yes ☐ No		amily member incarcerated □ Lack ey □ Emotional loss □ Health	□ Not at all Is it hard to □ Not at all	(0) ☐ Somewhat comfort your child (0) ☐ Somewhat	at (1) D Very much (2	•
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:	*Positive screen = numbered *If positive, see Periodicity S Postnatal Depression Scale	Schedule for link to Edinburgh (EPDS) ks: (Check one for each question	Is it hard to ☐ Not at all Is it hard to ☐ Not at all	(0) ☐ Somewhat put your child to s (0) ☐ Somewhat	n a schedule or routine at (1) □ Very much (2)
Psychosocial/Behavioral What is your family's living situation?	☐ Not at all (0) ☐ Several da☐ Nearly every day (3) Feeling down, depressed, or h	ys (1) ☐ More than ½ the days (2) opeless	Does your o	child have trouble	at (1) Uery much (2	
Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? ☐ Yes ☐ No	☐ Not at all (0) ☐ Several da☐ Nearly every day (3)	ys (1) ☐ More than ½ the days (2)				
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No	Baby Pediatric Symptom Ch		Social Lang	ental Surveillance guage and Self–l kes sounds that le	e (✓ Check those that a help □ Child smiles re et you know if he/she is	sponsively happy
Who do you contact for help and/or support?		d responses 3 or greater in <u>any</u> of luation and/or investigation may	Verbal Lan cooing sour	. .	re and Receptive) □ C	hild makes short

be needed.

Subscale 1 (✓ Check one for each question)

Does your child have a hard time being with people?

□ Not at all (0) □ Somewhat (1) □ Very much (2)

Does your child have a hard time in new places?

□ Not at all (0) □ Somewhat (1) □ Very much (2)

Does your child have a hard time with change?

□ Not at all (0) □ Somewhat (1) □ Very much (2)

Does your child mind being held by other people?

□ Not at all (0) □ Somewhat (1) □ Very much (2)

Subscale 1 score ____

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

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

Child care plans?

☐ Drugs (prescription or otherwise)_

Gross Motor ☐ Child lifts head and chest when on stomach ☐ Child keeps head steady when held in sitting position

Fine Motor □ Child can open and shut hands □ Child can briefly bring hands together



Screen Date		2 Month Form, Page	е
Name	DOB	Age Sex: 🗆 M 🔘	F

General Health ☐ Growth plotted on growth chart	Age Appropriate Health Education/Anticipatory Guidance (Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)	Plan of Care Assessment
☐ Growth plotted on growth chart	information: https://brightfutures.aap.org)	
Do you think your child sees okay? ☐ Yes ☐ No		□ Well Child □ Other Diagnosis
Do you think your child hears okay? ☐ Yes ☐ No	Social Determinants of Health, Parental/Family Health and	
	Well-Being, Infant Behavior and Development, Nutrition and	Immunizations
Oral Health	Feeding, and Safety	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Water source: ☐ Public ☐ Well ☐ Tested	☐ Discussed ☐ Handouts Given	
		Labs
Nutrition/Sleep	Questions/Concerns/Notes	
☐ Breastfeeding - Frequency	-	_
☐ Bottle feeding - Amount Frequency		_
□ Formula □ Normal elimination		Referrals ☐ Maternal depression - Help4WV.com/1-844-435-7498
□ Normal sleeping patterns		□ Developmental
□ Place on back to sleep		□ Other
☐ Sleeps 3 to 4 hours at a time		-
Concerns and/or questions		☐ Right from the Start (RFTS) 1-800-642-9704
		☐ Birth to Three (BTT) 1-800-642-9704
		☐ Children with Special HealthCare Needs (CSHCN)
		1-800-642-9704
Physical Examination (N=Normal, Abn=Abnormal)		☐ Women, Infants and Children (WIC) 1-304-558-0030
General Appearance □ N □ Abn		
Skin	-	Medical Necessity
Neurological N Abn	-	For treatment plans requiring authorization, please complet
Reflexes		page 3. Contact a HealthCheck Regional Program Specialist for
Head		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Fontanelles	-	_
Neck	-	_
Eyes	-	Follow Up/Next Visit
Red Reflex		
Ocular Alignment		Other
Ears		-
Nose		-
Oral Cavity/Throat		☐ Screen has been reviewed and is complete
Lung		_
Heart		
Pulses		
Abdomen		
Genitalia		
Back		Please Print Name of Facility or Clinician
Hips		- I loade I fine Name of Lacinty of Chillician
Extremities		_
		_
Signs of Abuse/Neglect ☐ Yes ☐ No		Signature of Clinician/Title
		-

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

1	NA.	۸n	th	E,	٦rm
4	IVI	0 I I	τn	-	1FM

Name			DOB		A	.ge	Sex: □ M □ F
Weight Length Weight for	Length HC	Pulse	BP (optional)	Resp	Temp	Pulse Ox (op	itional)
Allergies NKDA							
Current meds None							
□ Foster child	□ Kinship place	ement	C	Child with spec	ial health care needs		
Accompanied by ☐ Parent ☐ Grandparent ☐ Fe	oster parent □ Foster org	ganization		г	☐ Other		
Medical History ☐ Initial screen ☐ Periodic screen ☐ Family health history reviewed ☐ In utero substance exposure ☐ Yes ☐ No ☐ Maternal Hep C exposure ☐ Yes ☐ No ☐ High birth score ☐ Yes ☐ No	□ Non What k □ Rela □ Chilc emotion suppor insurar	e □ Slight □ Modera ind of stress? (✓ Che tionships (partner, fami d care □ Drugs □ Alc nal and/or sexual) □ F	ck those that apply) ily and/or friends) □ School/work ohol □ Violence/abuse (physical, amily member incarcerated □ La ney □ Emotional loss □ Health	Does you Does you Does you Not a lock of Is your Is it har	our child have a hard at all (0) Somewh child fussy or irritable at all (0) Somewh d to comfort your chi at all (0) Somewh	nat (1)	(2) (2) (2)
Recent injuries, surgeries, illnesses, visits to other propositions: Psychosocial/Behavioral What is your family's living situation? Do you have the things you need to take care of you seat, diapers, etc.)? Yes No Do you have concerns about meeting basic family no monthly (food, housing, heat, etc.)? Yes No	Matern *Positi *If pos Postna Feeling Little in □ Not a □ Neal Feeling □ Not a	ve screen = numbered itive, see Periodicity Statal Depression Scale gs over the past 2 weet terest or pleasure in do at all (0) Several darly every day (3) down, depressed, or he	eks: (✓ Check one for each quest plant things lays (1) ☐ More than ½ the days	Subsca Is it har Subsca (2) Not a Does you Subsca Devel	le 2 score le 3 (✓ Check one for each question) d to keep your child on a schedule or routine? at all (0)		
Who do you contact for help and/or support? Are you and/or your partner working outside home? Child care Child has ability to separate from parents/caregivers Child exposed to □ Cigarettes □ E-Cigarettes/Va □ Drugs (prescription or otherwise)	*Positive that is the second to the second that is the second to the second that is the s	ubscales. Further eva ded. ale 1 (✓ Check one for	d responses 3 or greater in any aluation and/or investigation metaleach question) me being with people? (1) □ Very much (2) me in new places? (1) □ Very much (2) me with change? (1) □ Very much (2)	of Social □ Child Verbal voices Gross wrists v Fine M	Language and Self- d can look for you or a Language (Express ☐ Child can make e Motor ☐ Child can s when on stomach ☐ otor ☐ Child can ke	ce (* Creck trose trainhelp	ugh out loud en upset Child can turn to ls f on elbows and om stomach to back sted □ Child can

Health,
Resources
BUREAU FOR PUBLIC HEALTH

Screen	Date		

4 Month Form, Page 2

Name	DOB	Age Sex: 🗆 M 🗆 F
General Health	Signs of Abuse/Neglect ☐ Yes ☐ No	Plan of Care
☐ Growth plotted on growth chart		Assessment
Do you think your child sees okay? ☐ Yes ☐ No	Age Appropriate Health Education/Anticipatory	□ Well Child □ Other Diagnosis
Do you think your child sees okay? ☐ Yes ☐ No	Guidance (Consult Bright Futures, Fourth Edition. For further	
Do you tilling your offine floats onay? In 165 In 165	information: https://brightfutures.aap.org)	
Oral Health	Social Determinants of Health, Infant Behavior and Development,	Immunizations
Water source: ☐ Public ☐ Well ☐ Tested	Oral Health, Nutrition and Feeding, and Safety	□ UTD □ Given, see immunization record □ Entered into WVSIIS
	☐ Discussed ☐ Handouts Given	Laka
Nutrition/Sleep		Labs
☐ Breastfeeding - Frequency	Questions/Concerns/Notes	☐ Hemoglobin/hematocrit (<i>if high risk</i>) ☐ Other
☐ Bottle feeding - Amount Frequency ☐ Formula	Questions/concerns/Notes	LI Othor
☐ Juice ☐ Water		_
☐ Has started solid foods ☐ Normal eating habits		
□ Vitamins		_
☐ Normal elimination		Referrals Maternal depression - Help4WV.com/1-844-435-7498
☐ Normal sleeping patterns		☐ Developmental
☐ Place on back to sleep		□ Other
*Anemia Risk (Hemoglobin/Hematocrit)		D Dight from the Start (DETS) 4 900 642 9704
□ Low risk □ High risk		☐ Right from the Start (RFTS) 1-800-642-9704 ☐ Birth to Three (BTT) 1-800-642-9704 ☐
· ·		☐ Children with Special HealthCare Needs (CSHCN)
*See Periodicity Schedule for Risk Factors		1-800-642-9704
Physical Examination (N=Normal, Abn=Abnormal)		☐ Women, Infants and Children (WIC) 1-304-558-0030
- · · · · · · · · · · · · · · · · · · ·		
General Appearance N Abn	— - <u></u>	Medical Necessity
Skin		For treatment plans requiring authorization, please complete
Neurological □ N □ Abn Reflexes □ N □ Abn		page 3. Contact a HealthCheck Regional Program Specialist for
Head		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Fontanelles		_
Neck		_
Eyes		Follow Up/Next Visit □ 6 months of age
Red Reflex		□ Other_
Ocular Alignment		_
Ears		
Nose		☐ Screen has been reviewed and is complete
Oral Cavity/Throat		_
Lung		_
Heart		_
Pulses		
Abdomen		Please Print Name of Facility or Clinician
Genitalia N Abn		
Back □ N □ Abn Hips □ N □ Abn	 - <u></u>	_
Extremities		Signature of Clinician/Title
		-

Screen Date		Early and Periodic			ent of Health and Human Re tment (EPSDT) HealthCheck		ventive Health Scree	n	6 Month Form
Name				•			Age		Sex: □M □F
Weight	_ Length	Weight for Length	HC	Pulse	BP (optional)	Resp	Temp	Pulse Ox (option	onal)
Allergies □ NKDA	Α								
Current meds □ I	None								
☐ Foster child	 	Kii	nship placement		🗆 0	Child with specia	health care needs		
Accompanied by	□ Parent □ G	randparent □ Foster parent	□ Foster organizati	on		[Other		
Medical Histor ☐ Initial screen ☐ Family health h	☐ Periodic s	creen d	□ None □ SI What kind of □ Relationship	light ☐ Moderate stress? (✓ Check os (partner, family	our family under <u>now</u> ? ☐ Severe those that apply) and/or friends) ☐ School/work ol ☐ Violence/abuse (physical,	Does your Does you	ale 2 (✓ Check one for our child cry a lot? at all (0) □ Somewhat our child have a hard tir at all (0) □ Somewhat	(1) □ Very much (2 me calming down?	•
Maternal Hep C ex High birth score [kposure □ Y □ Yes □ No	es □ No	emotional and support/help [insurance □ (/or sexual) □ Fan □ Financial/money	nily member incarcerated □ La	ck of Is your Not a Is it har	child fussy or irritable? at all (0) Somewhat d to comfort your child? at all (0) Somewhat all (2) Somewhat ale 2 score	(1) □ Very much (2 (1) □ Very much (2)
•	•	s, visits to other providers and/or	Maternal Dep *Positive scre *If positive, se	een = numbered r	lealth Questionnaire (PHQ-2) responses 3 or greater hedule for link to Edinburgh PDS)	Subsca Is it har	ale 3 (✓ Check one for ord to keep your child on at all (0) □ Somewhat	each question) a schedule or routine	
Psychosocial/ What is your family		n?	Little interest o	or pleasure in doing) □ Several days	s: (✓ <i>Check one for each questi</i> g things (1) □ More than ½ the days (2	☐ Not a 2) Is it har	rd to put your child to sle at all (0) □ Somewhat rd to get enough sleep b	(1) □ Very much (2 pecause of your child	?
	nings you need t	kay □ Poor o take care of your baby (crib, ca	or -	depressed, or hop ☐ Several days	peless (1) □ More than ½ the days (2	Does y	at all (0) Somewhat our child have trouble s at all (0) Somewhat ale 3 score	taying asleep? (1) □ Very much (2)
		ing basic family needs daily and/ ? □ Yes □ No					opmental pmental Surveillance	(√Check those that a	apply)
Who do you conta	ct for help and/o	r support?	Baby Pediatri	c Symptom Chec	cklist (BPSC)		Language and Self-he	•	
Child care		ng outside home? ☐ Yes ☐ No	*Positive scre	en = numbered r	responses 3 or greater in <u>any</u> ation and/or investigation ma	of Verbal y □ Child	Language (Expressive d can make sounds like Motor □ Child can roll	and Receptive) □ C "ga," "ma," or "ba"	hild can babble

Subscale 1 (✓ Check one for each question)

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

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

☐ Drugs (prescription or otherwise)_

☐ Access to firearm(s)/weapon(s)

- Does your child have a hard time being with people?
- □ Not at all (0) □ Somewhat (1) □ Very much (2)
- Does your child have a hard time in new places?
- □ Not at all (0) □ Somewhat (1) □ Very much (2)
- Does your child have a hard time with change?
- □ Not at all (0) □ Somewhat (1) □ Very much (2)
- Does your child mind being held by other people?

☐ Not at all (0)	☐ Somewhat (1)	☐ Very much (2)
Subscale 1 score	Э	

can sit briefly without support

Fine Motor □ Child can pass a toy from one hand to another

☐ Child can rake small objects with 4 fingers ☐ Child can bang small objects on surface

Screen Date	•		

6 Month Form, Page 2

Name	DOB	Age Sex: 🗆 M 🗆 F
General Health	Lung	Plan of Care
☐ Growth plotted on growth chart	Heart	Assessment
Do you think your child sees okay? ☐ Yes ☐ No	Pulses	□ Well Child □ Other Diagnosis
Do you think your child hears okay? ☐ Yes ☐ No	Abdomen	
Do you think your child hears okay! I les I No	Genitalia	Immunizations
Oral Health	Back	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Tooth eruption ☐ Yes ☐ No	Hips	-
Current oral health problems	Extremities	Labs
Water source ☐ Public ☐ Well ☐ Tested		□ Blood lead (if high risk) (enter into WVSIIS)
Fluoride supplementation ☐ Yes ☐ No	Signs of Abuse/Neglect ☐ Yes ☐ No	☐ TB skin test (if high risk)
Fluoride varnish applied (apply every 3 to 6 months)		Other
□ Yes □ No		
Nutrition/Sleep ☐ Breastfeeding - Frequency		_
☐ Bottle feeding - Amount Frequency	Age Appropriate Health Education/Anticipatory	Referrals ☐ Maternal depression - Help4WV.com/1-844-435-7498
□ Formula	Guidance (Consult Bright Futures, Fourth Edition. For further	☐ Developmental
☐ Juice ☐ Water	Information: https://brightfutures.aap.org)	Other
☐ Has started solid foods ☐ Normal eating habits	Social Determinants of Health, Infant Behavior and Development,	Dight from the Ctart (DETC) 4 900 C42 0704
☐ Vitamins	Oral Health, Nutrition and Feeding, and Safety ☐ Discussed ☐ Handouts Given	☐ Right from the Start (RFTS) 1-800-642-9704 ☐ Birth to Three (BTT) 1-800-642-9704
□ Normal elemination	Discussed	☐ Children with Special HealthCare Needs (CSHCN)
□ Normal sleeping patterns □ Place on back to sleep		1-800-642-9704
Li Fiace on back to sleep	Questions/Concerns/Notes	☐ Women, Infants and Children (WIC) 1-304-558-0030
*Lead Risk		
□ Low risk □ High risk	-	Medical Necessity
	-	For treatment plans requiring authorization, please complete
*Tuberculosis Risk ☐ Low risk ☐ High risk		page 3. Contact a HealthCheck Regional Program Specialist for
L LOW HISK LI THIGHT HISK		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
*See Periodicity Schedule for Risk Factors		_
		Follow Up/Next Visit
Physical Examination (N=Normal, Abn=Abnormal)		─ □ Other
General Appearance		
Skin		_
Neurological		☐ Screen has been reviewed and is complete
Reflexes		—
Head		_
Fontanelles		—
Neck		
Eyes		Please Print Name of Facility or Clinician
Red Reflex		_
Ocular Alignment		
Ears		
Nose		Signature of Clinician/Title
Oral Cavity/Throat		

Screen Date Early and Periodic S	West Virginia Department of I			9 Month Forn	
Name					
Weight Length Weight for Length	HC Pulse	BP (optional) R	Resp Temp	Pulse Ox (optional)	
Allergies □ NKDA					
Current meds None					
□ Foster child □ Kinship			ith special health care needs		
Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐					
Medical History ☐ Initial screen ☐ Periodic screen ☐ Family health history reviewed	How much stress are you and your fam ☐ None ☐ Slight ☐ Moderate ☐ Se What kind of stress? (✓ Check those to ☐ Relationships (partner, family and/or	evere that apply)	Subscale 3 (✓ Check one for each is it hard to keep your child on a Not at all (0) ☐ Somewhat (all it hard to put your child to sle	a schedule or routine? (1) □ Very much (2) ep?	
Parental history of postpartum depression ☐ Yes ☐ No In utero substance exposure ☐ Yes ☐ No Maternal Hep C exposure ☐ Yes ☐ No High birth score ☐ Yes ☐ No	□ 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		□ Not at all (0) □ Somewhat (1) □ Very much (2) Is it hard to get enough sleep because of your child? □ Not at all (0) □ Somewhat (1) □ Very much (2) Does your child have trouble staying asleep? □ Not at all (0) □ Somewhat (1) □ Very much (2) Subscale 3 score		
Child recent injuries, surgeries, illnesses, visits to other providers and or hospitalizations:	Baby Pediatric Symptom Checklist (I *Positive screen = numbered respon- the 3 subscales. Further evaluation a be needed.	ses 3 or greater in <u>any</u> of	Developmental □ Developmental surveillanc Standardized Screening Tool □ ASQ3 □ Other tool		
Psychosocial/Behavioral What is your family's living situation?	Subscale 1 (✓ Check one for each question) Does your child have a hard time being with people		Results in child's record \(\subseteq \cdot \) Concerns and/or questions	∕es □ No	
Family relationships □ Good □ Okay □ Poor Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? □ Yes □ No	☐ Not at all (0) ☐ Somewhat (1) ☐ V Does your child have a hard time with c ☐ Not at all (0) ☐ Somewhat (1) ☐ V	· /ery much (2) ·hange? /ery much (2)	General Health	art.	
Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No			☐ Growth plotted on growth char Do you think your child sees ok — Do you think your child hears of	ay? □ Yes □ No	
Who do you contact for help and/or support?	Subscale 2 (✓ Check one for each que Does your child cry a lot?	estion)	Oral Health Tooth eruption □ Yes □ No		
Are you and/or your partner working outside home? ☐ Yes ☐ No	□ Not at all (0) □ Somewhat (1) □ V	ery much (2)	Current oral health problems		

Does your child have a hard time calming down?

Is your child fussy or irritable?

Is it hard to comfort your child?

Subscale 2 score _

□ Not at all (0) □ Somewhat (1) □ Very much (2)

□ Not at all (0) □ Somewhat (1) □ Very much (2)

□ Not at all (0) □ Somewhat (1) □ Very much (2)

Child care

☐ Drugs (prescription or otherwise)_

☐ Access to firearm(s)/weapon(s)

Child has ability to separate from parents/caregivers ☐ Yes ☐ No

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

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

Current oral health problems _

Water source ☐ Public ☐ Well ☐ Tested

Fluoride supplementation ☐ Yes ☐ No

Fluoride varnish applied (apply every 3 to 6 months)

☐ Yes ☐ No _____

Screen Date			9 Month Form, Page 2
Name	DOB	Age	Sex: 🗆 M 🗆 F

Nutrition/Sleep		Age Appropriate Health Education/Anticipatory	Plan of Care
☐ Breastfeeding - Fr	equency	Guidance (Consult Bright Futures, Fourth Edition. For further	Assessment
	nountFrequency	information: https://brightfutures.aap.org)	☐ Well Child ☐ Other Diagnosis
☐ Formula		Social Determinants of Health, Infant Behavior and Development,	
☐ Juice ☐ Water		Discipline, Nutrition and Feeding, and Safety	Immunizations
☐ Has started solid f	oods □ Table foods □ Normal eating habits	☐ Discussed ☐ Handouts Given	□ UTD □ Given, see immunization record □ Entered into WVSIIS
☐ Vitamins			
□ Normal elimination	1	O	Labs
☐ Normal sleeping p	atterns	Questions/Concerns/Notes	☐ Blood lead (if high risk) (enter into WVSIIS)
☐ Place on back to s	leep		_ □ Other
*Lead Risk			
☐ Low risk ☐ High	risk		Referrals
*See Periodicity Sc	hedule for Risk Factors		☐ Developmental
See Ferrodicity Sc.	reduce for Mak Paciora		_ □ Other
Physical Examin	nation (N=Normal, Abn=Abnormal)		☐ Right from the Start (RFTS) 1-800-642-9704
General Appearance	□ N □ Abn		_ ☐ Birth to Three (BTT) 1-800-642-9704
Skin	□ N □ Abn		☐ Children with Special HealthCare Needs (CSHCN)
Neurological	□ N □ Abn		1-800-642-9704
Reflexes	□ N □ Abn		☐ Women, Infants and Children (WIC) 1-304-558-0030
Head	□ N □ Abn		_
Fontanelles	□ N □ Abn		Madical Necessity
Neck	□ N □ Abn		Medical Necessity For treatment plans requiring authorization, please complete
Eyes	□ N □ Abn		page 3. Contact a HealthCheck Regional Program Specialist for
Red Reflex	□ N □ Abn		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Ocular Alignment	□ N □ Abn		
Ears	□ N □ Abn		_
Nose	□ N □ Abn		Follow Up/Next Visit 12 months of age
Oral Cavity/Throat	□ N □ Abn		
Lung	□ N □ Abn		Other
Heart	□ N □ Abn		_
Pulses	□ N □ Abn		□ Screen has been reviewed and is complete
Abdomen	□ N □ Abn		— Docteen has been reviewed and is complete
Genitalia	□ N □ Abn		
Back	□ N □ Abn		
Hips	□ N □ Abn		_
Extremities	□ N □ Abn		_
Signs of Abuse/Neg	lect ☐ Yes ☐ No		Please Print Name of Facility or Clinician
			_
			_
			Signature of Clinician/Title
			-

Screen Date_		Early and Periodic S			ent of Health and Human Reatment (EPSDT) HealthCheck		ventive Health Scr	een	12 Month Forr	
Name					DOB		A	ge	Sex: □ M □ F	
Weight	Length	Weight for Length	HC	Pulse	BP (optional)	_ Resp	Temp	Pulse Ox (c	ptional)	
Allergies □ N	NKDA									
Current meds	s □ None									
☐ Foster child	d	□ Kinsh	ip placement_			hild with specia	l health care needs_			
Accompanied	d by □ Parent □ G	randparent □ Foster parent □ F	oster organiz	ation			□ Other			
Medical His ☐ Initial screet ☐ Family hea	-		□ None □ What kind	Slight ☐ Moderate of stress? (✓ Chec		ls it ha □ Not	ale 3 (✓ Check one for the control of the control	on a schedule or rout at (1) □ Very much		
Parental history of postpartum depression ☐ Yes ☐ No		☐ Child care emotional a support/help	e □ Drugs □ Alcol nd/or sexual) □ Fa o □ Financial/mone	nol □ Violence/abuse (physical, mily member incarcerated □ Lar y □ Emotional loss □ Health	ck of Is it ha	at all (0) ☐ Somewh rd to get enough sleep at all (0) ☐ Somewh	o because of your ch at (1) □ Very much	ild?		
	•	es □ No es □ No	insurance Other				Does your child have trouble staying asleep? □ Not at all (0) □ Somewhat (1) □ Very much (2)			
						Subsca	ale 3 score			
Child recent in or hospitalizati	,	esses, visits to other providers and/	*Positive s	cales. Further eval	cklist (BPSC) responses 3 or greater in <u>any</u> uation and/or investigation ma	Develo Social (point t	opmental popmental Surveilland Language and Self- to request an object)	- help □ *Child can ր □ Child can imitate	protoimperative point	
Psychosocial/Behavioral What is your family's living situation?		Does your o ☐ Not at all Does your o ☐ Not at all	(0) □ Somewhat (child have a hard tim (0) □ Somewhat (e being with people? 1) □ Very much (2) ie in new places? 1) □ Very much (2)	Verbal □ *Chi "Dada" "Mama	d can look for hidden Language (Expressi Id can imitate vocaliza or "Mama" specificall "" "Dada," or persona	ve and Receptive) ☐ ations and sounds ☐ ly ☐ Child can use 1 I name	Child can use word other than		
Do you have th	amily relationships □ Good □ Okay □ Poor o you have the things you need to take care of your baby (crib, car eat, diapers, etc.)? □ Yes □ No		Does your child have a hard time with change? □ Not at all (0) □ Somewhat (1) □ Very much (2) Does your child mind being held by other people? □ Not at all (0) □ Somewhat (1) □ Very much (2)			stand v Fine M	Gross Motor ☐ Child can take first independent steps ☐ 0 stand without support Fine Motor ☐ Child can drop an object in a cup ☐ Child can small objects with 2 finger pincer grasp ☐ Child can pick u			
•		ing basic family needs daily and/or ? □ Yes □ No		score (✓ Check one for e			nce of these milesto	nes = Autism Scree	en	
Who do you co	contact for help and/o	r support?	Does your o ☐ Not at all	child cry a lot? (0) □ Somewhat (1) □ Very much (2)	Conce	rns and/or questions_			
•	or your partner workin	ng outside home? ☐ Yes ☐ No	☐ Not at all	child have a hard tim (0) □ Somewhat (I fussy or irritable?	e calming down? 1) □ Very much (2)		ral Health			

□ Not at all (0) □ Somewhat (1) □ Very much (2)

□ Not at all (0) □ Somewhat (1) □ Very much (2)

Is it hard to comfort your child?

Subscale 2 score _

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

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

☐ Drugs (prescription or otherwise)_

☐ Access to firearm(s)/weapon(s)

Concerns and/or questions_

☐ Growth plotted on growth chart

Do you think your child sees okay? ☐ Yes ☐ No

Do you think your child hears okay? ☐ Yes ☐ No



Screen Date			12 Month Form, Page 2
Name	DOB	Age	Sex: □M □F

Oral Health	Pulses	ПΝ	□ Abn	Plan of Care
Dental referral required at 12 months	Abdomen	ПΝ	□ Abn	Assessment
Tooth eruption ☐ Yes ☐ No	Genitalia	ПΝ	□ Abn	☐ Well Child ☐ Other Diagnosis
Current oral health problems	Back	ПΝ	□ Abn	_
Water source ☐ Public ☐ Well ☐ Tested	Hips	ПΝ	□ Abn	Immunizations
Fluoride supplementation ☐ Yes ☐ No	Extremities		□ Abn	□ UTD □ Given, see immunization record □ Entered into WVSIIS
Fluoride varnish applied (apply every 3 to 6 months)	LAticilities			-
☐ Yes ☐ No	Signs of Abus	se/Nealect	☐ Yes ☐ No	Labs
	J. J			☐ Hemoglobin/hematocrit (required at 12 months)
Nutrition/Sleep				☐ Blood lead (required at 12 months) (enter into WVSIIS)
☐ Breastfeeding - Frequency	-			☐ TB skin test (if high risk)
☐ Bottle feeding - Amount Frequency	Age Approp	oriate Healt	h Education/Anticipatory	□ Other
□ Formula	Guidance (0	Consult Bright	Futures, Fourth Edition. For further	
Plans for weaning	information: htt	tps://brightfutu	res.aap.org)	
□ Milk □ Juice □ Water	Social Determi	inants of Healt	h, Establishing Routines, Feeding and	
☐ Has started solid foods ☐ Table foods ☐ Normal eating habits	Appetite Chang	ges, Establish	ing a Dental Home, and Safety	Referrals
☐ Vitamins	☐ Discussed	☐ Han	douts Given	☐ Developmental ☐ Dental ☐ Blood lead ≥5ug/dl
□ Normal elimination	_			□ Other
☐ Normal sleeping patterns	Questions/0	Concerns/N	lotes	
*Anemia Risk (Hemoglobin/Hematocrit)				□ Birth to Three (BTT) 1-800-642-9704
Hemoglobin/hematocrit required at 12 months				☐ Children with Special HealthCare Needs (CSHCN)
*Lead Risk				1-800-642-9704
Blood lead required at 12 months				□ Women, Infants and Children (WIC) 1-304-558-0030
2100d 10dd 10quil od de 12 moneno				_
*Tuberculosis Risk				
☐ Low risk ☐ High risk				Medical Necessity
*See Periodicity Schedule for Risk Factors				For treatment plans requiring authorization, please complete
• • • • • • • • • • • • • • • • • • •				page 3. Contact a HealthCheck Regional Program Specialist fo
Physical Examination (N=Normal, Abn=Abnormal)				assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
•				_
General Appearance				
Skin				Follow Up/Next Visit 15 months of age
Neurological				— □ Other
Reflexes				_
Head				_
Fontanelles				☐ Screen has been reviewed and is complete
Neck				_
Eyes				_
Red Reflex				_
Ocular Alignment				_
Ears				Please Drint Name of Escility or Olivinia
Nose				Please Print Name of Facility or Clinician
Oral Cavity/Throat				_
Lung				_
Heart				Circusture of Clinician/Title
	-			Signature of Clinician/Title

Screen Date Early and Periodic	West Virginia Departm Screening, Diagnosis, and Trea	ent of Health and Human Reso atment (EPSDT) HealthCheck P	urces rogram Preventive	Health Screen	15	Month Forr
Name		DOB		Age	Sex:	: 🗆 M 🗆 F
Weight Length Weight for Length	HC Pulse	BP (optional)	Resp T	emp	_ Pulse Ox (optional)_	
Allergies □ NKDA						
Current meds ☐ None						
□ Foster child □	I Kinship placement	Cr	nild with special health	care needs		
Accompanied by ☐ Parent ☐ Grandparent ☐ Foster parent ☐	l Foster organization		□ Other _			
Medical History ☐ Initial screen ☐ Periodic screen ☐ Family health history reviewed	_ □ Relationships (partner, family	e □ Severe k those that apply) y and/or friends) □ School/work	Is it hard to keep ☐ Not at all (0) Is it hard to put	Check one for each p your child on a sc ☐ Somewhat (1) your child to sleep?	hedule or routine? Uery much (2)	
Parental history of postpartum depression ☐ Yes ☐ No In utero substance exposure ☐ Yes ☐ No Maternal Hep C exposure ☐ Yes ☐ No	□ Child care □ Drugs □ Alcol emotional and/or sexual) □ Fal support/help □ Financial/mone insurance □ Other	□ Not at all (0) □ Somewhat (1) □ Very much (2) Is it hard to get enough sleep because of your child? □ Not at all (0) □ Somewhat (1) □ Very much (2) Does your child have trouble staying asleep? □ Not at all (0) □ Somewhat (1) □ Very much (2) Subscale 3 score				
Child recent injuries, surgeries, illnesses, visits to other providers and or hospitalizations:	Baby Pediatric Symptom Che *Positive screen = numbered	cklist (BPSC) responses 3 or greater in <u>any</u> of uation and/or investigation may	Social Language (point to comme	I Surveillance (√Cage and Self–help I gent on an interesting	heck those that apply) □ *Child can prodeclar g object/event-will look	rative point alternatively
Psychosocial/Behavioral What is your family's living situation?	Subscale 1 (✓ Check one for e Does your child have a hard tim Not at all (0) ☐ Somewhat (ne being with people? 1) □ Very much (2)	something to ge like "Where's yo	et help □ Child can our ball?" or "Where	☐ Child can point to as look around when you 's your blanket?" ☐ Cl	ı say things hild can
Family relationships □ Good □ Okay □ Poor Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? □ Yes □ No	Does your child have a hard tim □ Not at all (0) □ Somewhat (Does your child have a hard tim □ Not at all (0) □ Somewhat (Verbal Langua words other that unknown langua	imitate scribbling □ Child can drink from a cup with little sp Verbal Language (Expressive and Receptive) □ Child can words other than names □ Child can speak in sounds like unknown language □ Child can follow directions that do not			
Do you have concerns about meeting basic family needs daily and/o monthly (food, housing, heat, etc.)? ☐ Yes ☐ No	Does your child mind being held Not at all (0) Somewhat (Subscale 1 score	1) Uery much (2)	up a few steps	□ Child can run	o pick up objects □ Ch	
Who do you contact for help and/or support?	Subscale 2 (✓ Check one for e	ach question)		Child can make ma I take object out of a	rks with a crayon □ C a container	тіна сап агор
Are you and/or your partner working outside home? ☐ Yes ☐ No Child care	Does your child cry a lot? ☐ Not at all (0) ☐ Somewhat (☐ Does your child have a hard tim	1) □ Very much (2)	*Absence of th Concerns and/o	nese milestones = A or questions	Autism Screen	

□ Not at all (0) □ Somewhat (1) □ Very much (2)

□ Not at all (0) □ Somewhat (1) □ Very much (2)

□ Not at all (0) □ Somewhat (1) □ Very much (2)

Is your child fussy or irritable?

Is it hard to comfort your child?

Subscale 2 score _

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

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

☐ Drugs (prescription or otherwise)_

☐ Access to firearm(s)/weapon(s)

General Health

☐ Growth plotted on growth chart

Do you think your child sees okay? \square Yes \square No Do you think your child hears okay? \square Yes \square No



Screen	Data		
3616611	Date		

15 Month Form, Page 2

Name		DOB	Age Sex: 🗆 M 🔻
Oral Health		Hips □ N □ Abn	Plan of Care
Date of last dental v	visit	Extremities	Assessment
Current oral health	problems		☐ Well Child ☐ Other Diagnosis
Water source ☐ P	ublic □ Well □ Tested	Signs of Abuse/Neglect ☐ Yes ☐ No	
• • •	ntation ☐ Yes ☐ No		Immunizations
•	plied (apply every 3 to 6 months)		□ UTD □ Given, see immunization record □ Entered into WVSIIS
☐ Yes ☐ No			
		Age Appropriate Health Education/Anticipatory	Labs
Nutrition/Sleep		Guidance (Consult Bright Futures, Fourth Edition. For further	☐ Hemoglobin/hematocrit (<i>if high risk</i>)
☐ Breastfeeding - F	requency	information: https://brightfutures.aap.org)	☐ Blood lead (if high risk) (enter into WVSIIS)
	Amount Frequency	Communication and Social Development, Sleep Routines and	□ Other
		Issues, Temperament, Development, Behavior, and Discipline,	
Plans for weaning_		Healthy Teeth, and Safety	
☐ Milk ☐ Juice ☐		☐ Discussed ☐ Handouts Given	Referrals
☐ Normal eating ha	abits		☐ Developmental ☐ Dental
☐ Vitamins		Questions/Concerns/Notes	□ Other
□ Normal elimination		—	
☐ Normal sleeping	patterns	—	— ☐ Birth to Three (BTT) 1-800-642-9704
			☐ Children with Special HealthCare Needs (CSHCN)
	moglobin/Hematocrit)		1-800-642-9704
☐ Low risk ☐ Hig	h risk		─ ☐ Women, Infants and Children (WIC) 1-304-558-0030
*Lead Risk			_
☐ Low risk ☐ Hig	h risk		Medical Necessity
*See Periodicity S	chedule for Risk Factors		For treatment plans requiring authorization, please complete
			page 3. Contact a HealthCheck Regional Program Specialist for
Physical Exami	ination (N=Normal, Abn=Abnormal)		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
-	ee □N □Abn		_
Skin	□ N □ Abn		_
Neurological	□ N □ Abn		Follow Up/Next Visit □ 18 months of age
Reflexes	□ N □ Abn		□ Other
Head	□ N □ Abn		
Neck	□ N □ Abn		_
Eyes	□ N □ Abn		─ □ Screen has been reviewed and is complete
Red Reflex	□ N □ Abn		_
Ocular Alignment	□ N □ Abn		_
Ears	□ N □ Abn		_
Nose	□ N □ Abn		_
Oral Cavity/Throat	□ N □ Abn		_
Lung	□ N □ Abn		
Heart	□ N □ Abn		Please Print Name of Facility or Clinician
Pulses	□ N □ Abn		
Abdomen	□ N □ Abn		
Genitalia	□ N □ Abn		
Back	□ N □ Abn		Signature of Clinician/Title
	_ · · _ /		-

Screen Date	Early and Periodic S			ent of Health and Human tment (EPSDT) HealthCh		entive Health Screen	18 Month Form		
Name				DOB		Age	Sex: 🗆 M 🗆 F		
Weight Length Weight	nt for Length	HC	Pulse	BP (optional)	Resp	Temp	Pulse Ox (optional)		
Allergies □ NKDA									
Current meds ☐ None									
□ Foster child	□ Kinsl	hip placement_			_ □ Child with specia	al health care needs			
Accompanied by ☐ Parent ☐ Grandparent	☐ Foster parent ☐	Foster organiz	ation		□	Other			
Medical History ☐ Initial screen ☐ Periodic screen ☐ Family health history reviewed		□ None □ What kind o	Slight □ Moderate of stress? (✓ Check		☐ M-CH Results i	m screening completed AT-R/F □ Other tool_ in child's record □ Ye	d with an Autism Specific Tool		
Parental history of postpartum depression	l Yes □ No		☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (phy emotional and/or sexual) ☐ Family member incarcerated			al Health th plotted on growth char	rt		
	In utero substance exposure ☐ Yes ☐ No Maternal Hep C exposure ☐ Yes ☐ No		support/help ☐ Financial/money ☐ Emotional loss ☐ Health insurance ☐ Other			Do you think your child sees okay? ☐ Yes ☐ No Do you think your child hears okay? ☐ Yes ☐ No			
Child recent injuries, surgeries, illnesses, visits or hospitalizations:	•	Does your o	hild seem nervous o □ Somewhat □ V	ery much	Current of Water so	ast dental visit_ oral health problems ource □ Public □ Well	☐ Tested		
Psychosocial/Behavioral What is your family's living situation? Family relationships □ Good □ Okay □ Poor Do you have the things you need to take care of your baby (crib, car seat, diapers, etc.)? □ Yes □ No		☐ Not at all Does your c ☐ Not at all Does your c	☐ Somewhat ☐ V hild have a hard time	ery much things are not done a certair ery much with change?	Fluoride Yes [Nutrition	Fluoride supplementation			
		Does your o □ Not at all Does your o	☐ Somewhat ☐ V hild break things on ☐ Somewhat ☐ V hild have a hard time	purpose? ery much e calming down?	☐ Bottle☐ Formu ☐ Flans for				
Do you have concerns about meeting basic fan monthly (food, housing, heat, etc.)? ☐ Yes ☐		ls your child □ Not at all	☐ Somewhat ☐ V aggressive? ☐ Somewhat ☐ V	ery much	□ Norma □ Vitam				
Who do you contact for help and/or support?			take your child out ir □ Somewhat □ V	•	□ Norma				
Are you and/or your partner working outside ho	ome? □ Yes □ No				Hours of	sleep each night?			

☐ Developmental surveillance and screening completed with

Developmental

Standardized Screening Tool

Results in child's record ☐ Yes ☐ No

□ ASQ3 □ Other tool_

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

☐ Threatened with violence/abuse

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

☐ Scary experience that your child cannot forget_

☐ Drugs (prescription or otherwise)_

☐ Access to firearm(s)/weapon(s)

☐ Witnessed violence/abuse



Screen	Data		
ocreen	Date		

18 Month Form, Page 2

Name		DOB	Age Sex: □ M □ F
*Anemia Risk (Hem □ Low risk □ High *Lead Risk □ Low risk □ High		Age Appropriate Health Education/Anticipatory Guidance (Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org) Temperament, Development, Toilet Training, Behavior and	Plan of Care Assessment □ Well Child □ Other Diagnosis
*See Periodicity Sc	hedule for Risk Factors	Discipline, Communication and Social Development, Television Viewing and Digital Media, Healthy Nutrition, and Safety ☐ Discussed ☐ Handouts Given	Immunizations ☐ UTD ☐ Given, see immunization record ☐ Entered into WVSIIS
General Appearance	nation (N=Normal, Abn=Abnormal) D N D Abn D N D Abn	Questions/Concerns/Notes	Labs ☐ Hemoglobin/hematocrit (if high risk) ☐ Blood lead (if high risk) (enter into WVSIIS) ☐ Other
Neurological Reflexes Head Neck Eyes	□ N □ Abn		Referrals □ Developmental □ Dental □ Other
Red Reflex Ocular Alignment Ears Nose Oral Cavity/Throat Lung	□ N □ Abn		□ Birth to Three (BTT) 1-800-642-9704 □ Children with Special HealthCare Needs (CSHCN) 1-800-642-9704 □ Women, Infants and Children (WIC) 1-304-558-0030
Heart Pulses Abdomen Genitalia Back	□ N □ Abn		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.
Hips Extremities Signs of Abuse/Neg	□ N □ Abn		Follow Up/Next Visit 24 months of age
			□ Screen has been reviewed and is complete
			Please Print Name of Facility or Clinician
			Signature of Clinician/Title

Screen Date_		Early and Periodi			ment of Health and Hu eatment (EPSDT) Healt		es ram Preventive Health S	creen	24 Month For
Name		· · · · · · · · · · · · · · · · · · ·			DOB			Age	Sex: □ M □ I
Weight	Height	BMI I	IC	Pulse	BP (optional)	Resp_	Temp	Pulse Ox	(optional)
Allergies □ N	IKDA								
Current meds	□ None								
☐ Foster child	d		ip placement			□ Child with	n special health care needs_		
Accompanied	d by □ Parent □ Grand	dparent □ Foster parent	□ Foster organiz	zation					
Medical His □ Initial screen □ Family hea	n Periodic scree	n	□ None □ What kind	Slight ☐ Moder of stress? (✓ Che	d your family under <u>now</u> ? ate □ Severe eck those that apply) nily and/or friends) □ Sch		Developmental Developmental Surveilla □ Child can play alongsid □ Child can take off some	le other children, als	o called parallel play
	ry of postpartum depress	sion □ Yes □ No	☐ Child car emotional a support/hel	re □ Drugs □ Alo and/or sexual) □ f p □ Financial/mo	cohol □ Violence/abuse (Family member incarceratiney □ Emotional loss □	physical, ed □ Lack of	spoon ☐ Child can use 5 short phrase or sentence ☐ Child can name at leas ☐ Child's speech is 50%	0 words □ Child ca □ Child can follow 2 t 5 body parts, such	n combine 2 words into 2-step command as nose and hand
Child currently	receiving mental/behav	ioral health services?		Li Otriei			kick a ball □ Child can ju run with coordination □ C □ Child can stack objects	mp off the ground w Child can climb up a	ith 2 feet □ Child can ladder at a playground
		es, visits to other providers a	nd/ □ Not at all — Does your o	child seem nervou I □ Somewhat □ child seem sad or I □ Somewhat □	l Very much unhappy?		use his/her hands to turn can draw a line	objects like knobs, to	oys, and lids □ Child
•	Psychosocial/Behavioral What is your family's living situation?			child get upset who I □ Somewhat □ child have a hard t I □ Somewhat □ child break things	en things are not done a c I Very much ime with change? I Very much on purpose?	ertain way?	□ Autism screening completed with an Autism Spec □ M-CHAT-R/F □ Other tool Results in child's record □ Yes □ No		
Do you have c		[/] □ Poor basic family needs daily and l Yes □ No	Does your o □ Not at all Is your child	I □ Somewhat □ d aggressive?	ime calming down? I Very much				
Who do you co	ontact for help and/or su	pport?		I □ Somewhat □ take your child ou	•		General Health ☐ Growth plotted on grow	th chart	
Child care		utside home? ☐ Yes ☐ No	── □ Not at all	I □ Somewhat □ know what your c I □ Somewhat □	l Very much hild needs?		Do you think your child se	es okay? □ Yes	
		nts/caregivers □ Yes □ No -Cigarettes/Vaping □ Alcoh					Oral Health Date of last dental visit Current oral health proble	ms	

☐ Drugs (prescription or otherwise)

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

☐ 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

☐ Threatened with violence/abuse

☐ Access to firearm(s)/weapon(s)

☐ Witnessed violence/abuse

Continue on page 2

☐ Yes ☐ No _

Water source ☐ Public ☐ Well ☐ Tested

Fluoride varnish applied (apply every 3 to 6 months)

Fluoride supplementation ☐ Yes ☐ No



creen Date	24 Month Form, Page 2

Name_

DOB_

		la.
Nutrition/Sleep	Age Appropriate Health Education/Anticipatory	Plan of Care
□ Normal eating habits	Guidance (Consult Bright Futures, Fourth Edition. For further	Assessment
Fruits/vegetables/lean protein per day	information: https://brightfutures.aap.org)	☐ Well Child ☐ Other Diagnosis
□ Vitamins	Social Determinants of Health, Temperament and Behavior,	
□ Normal elimination	Assessment of Language Development, Toilet Training, and Safety	Immunizations
Toilet trained ☐ Yes ☐ No	☐ Discussed ☐ Handouts Given	□ UTD □ Given, see immunization record □ Entered into WVSIIS
□ Normal sleeping patterns		
Hours of sleep each night?	Questions/Concerns/Notes	Labs
	Questions/Concerns/Notes	☐ Hemoglobin/hematocrit (if high risk)
*Anemia Risk (Hemoglobin/Hematocrit)		□ Blood lead (required at 24 months) (enter into WVSIIS)
☐ Low risk ☐ High risk		_ □ TB skin test (if high risk)
*Lead Risk		_ ☐ Lipid profile (if high risk)
Blood lead required at 24 months		Other
•		=
*Tuberculosis Risk		
□ Low risk □ High risk		Referrals
*Dyslipidemia Risk		□ Developmental □ Dental □ Blood lead ≥5ug/dl
□ Low risk □ High risk		☐ Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
*Coo Bouladiaity Cabadula fay Bioly Footows		_ □ Other
*See Periodicity Schedule for Risk Factors		-
		- - - - - - - - - -
		□ Birth to Three (BTT) 1-800-642-9704
Physical Examination (N=Normal, Abn=Abnormal)		□ Children with Special HealthCare Needs (CSHCN)
General Appearance □ N □ Abn		- 1-800-642-9704
Skin		U Women, Infants and Children (WIC) 1-304-558-0030
Neurological		-
Reflexes		Medical Necessity
Head		For treatment plans requiring authorization, please complete
Neck		page 3. Contact a HealthCheck Regional Program Specialist for
Eyes		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Red Reflex		
Ocular Alignment		
Ears		Follow Up/Next Visit □ 30 months of age
Nose □ N □ Abn		G Others
Oral Cavity/Throat		Other
Lung		
Heart		☐ Screen has been reviewed and is complete
Pulses		
Abdomen		
Hips		Please Print Name of Facility or Clinician
Extremities		
Signs of Abuse/Neglect ☐ Yes ☐ No		
organo or Abdocatograda		
		Signature of Clinician/Title

_____ Age____ Sex: 🗆 M 🗆 F

Screen Date		Early and Periodic So			ilth and Human Resourd SDT) HealthCheck Pro		th Screen	30 Month Form
Name					DOB		Age	Sex: □M □F
Weight	Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (optional)_	
Allergies □ NKD	DA							
								· · · · · · · · · · · · · · · · · · ·
☐ Foster child _		□ Kinship	placement		Child	with special health care r	needs	· · · · · · · · · · · · · · · · · · ·
Accompanied by	y □ Parent □ Grandpar	rent □ Foster parent □ F	oster organization			□ Other		
Medical Histo □ Initial screen □ Family health	Dry ☐ Periodic screen n history reviewed		How much stress are □ None □ Slight □ What kind of stress ? □ Relationships (part	I Moderate □ Sever ? (✓ Check those that ner, family and/or frie	e <i>apply)</i> nds) □ School/work	Standardized Scree □ ASQ3 □ Other	tool	mpleted with
In utero substance exposure ☐ Yes ☐ No			☐ 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			Results in child's reco	□ Yes □ No	
	or hospitalizations:		Does your child seem ☐ Not at all ☐ Some Does your child seem	what □ Very much		,	growth chart ld sees okay? □ Yes □ No ld hears okay? □ Yes □ No	
Psychosocial What is your fam	nily's living situation?		☐ Not at all ☐ Somewhat ☐ Very much Does your child get upset when things are not done a certa			Oral Health		
Do you have con	Family relationships ☐ Good ☐ Okay ☐ Poor Do you have concerns about meeting basic family needs daily and/or nonthly (food, housing, heat, etc.)? ☐ Yes ☐ No		□ Not at all □ Some Does your child have □ Not at all □ Some Does your child have	a hard time with char what □ Very much trouble playing with c		Date of last dental visit Current oral health problems Water source □ Public □ Well □ Tested Fluoride supplementation □ Yes □ No		
Who do you cont	tact for help and/or suppo	rt?	□ Not at all □ Some Does your child break	things on purpose?			ed (apply every 3 to 6 months,)
Child care	our partner working outsion to separate from parents/o		□ Not at all □ Some Does your child have □ Not at all □ Some	a hard time calming o what □ Very much	lown?	Nutrition/Sleep ☐ Normal eating hab		
Child exposed to		garettes/Vaping □ Alcohol	Is your child aggression ☐ Not at all ☐ Some of the state of the sta	what □ Very much child out in public?		☐ Vitamins	n protein per day	
☐ Access to firea	arm(s)/weapon(s) s)/weapon(s) = □		□ Not at all □ Some	t your child needs?		Toilet trained ☐ Yes ☐ Normal sleeping pa	atterns	

□ Not at all □ Somewhat □ Very much

□ Not at all □ Somewhat □ Very much

Is it hard to get your child to obey you?

☐ 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

Continue on page 2

Hours of sleep each night?__



Name		DOB	Age Sex: □ M □ F
*Anemia Risk (Hem □ Low risk □ High	oglobin/Hematocrit) risk	Age Appropriate Health Education/Anticipatory	Plan of Care
*Lead Risk □ Low risk □ High	risk	Guidance (Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org) Social Determinants of Health, Temperament and Behavior,	Assessment ☐ Well Child ☐ Other Diagnosis
*Tuberculosis Risk □ Low risk □ High		Assessment of Language Development, Toilet Training, and Safety ☐ Discussed ☐ Handouts Given	Immunizations ☐ UTD ☐ Given, see immunization record ☐ Entered into WVSIIS
*See Periodicity Sc.	hedule for Risk Factors	Questions/Concerns/Notes	Labs ☐ Hemoglobin/hematocrit (if high risk) ☐ Blood lead (if not completed at 12 and/or 24 months or high risk)
Physical Examin	nation (N=Normal, Abn=Abnormal)		(enter into WVSIIS)
General Appearance	□ N □ Abn		☐ TB skin test (if high risk)
Skin	□ N □ Abn		_ □ Other
Neurological	□ N □ Abn		-
Reflexes	□ N □ Abn		
Head	□ N □ Abn		Referrals
Neck	□ N □ Abn		Developmental Dental
Eyes	□ N □ Abn		☐ Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
Red Reflex	□ N □ Abn		Other
Ocular Alignment	□ N □ Abn		-
Ears	□ N □ Abn		- □ Children with Special HealthCare Needs (CSHCN)
Nose	□ N □ Abn		1-800-642-9704
Oral Cavity/Throat	□ N □ Abn		□ Women, Infants and Children (WIC) 1-304-558-0030
Lung	□ N □ Abn		□ Birth to Three (BTT) transition planning
Heart	□ N □ Abn		Buttle Thee (BTT) tanditon planning
Pulses	□ N □ Abn		Medical Necessity
Abdomen	□ N □ Abn		For treatment plans requiring authorization, please complete
Genitalia	□ N □ Abn		page 3. Contact a HealthCheck Regional Program Specialist for
Back	□ N □ Abn		assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
Hips	□ N □ Abn		
Extremities	□ N □ Abn		
			Follow Up/Next Visit □ 3 years of age
Signs of Abuse/Neg	glect □ Yes □ No		□ Other
			☐ Screen has been reviewed and is complete
			Please Print Name of Facility or Clinician

Signature of Clinician/Title

Screen Date		Early and Periodic S			ith and Human Resourc SDT) HealthCheck Prog		Ith Screen	3 Year For
Name					_ DOB		Age	_ Sex: □ M □ F
Weight	Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (optional)	
Allergies □ NKD	Α							
Current meds □	None							
		□ Kinship Placement					EP/section 504 in place	
Accompanied by	☐ Parent ☐ Grand	dparent □ Foster parent □	Foster organization			Dother		
Oral Health			Developmental			Immunizations: Atta	ach current immunization recor	⁻ d
Date of last dental	l visit n problems		•	veillance (√Check the		□ UTD □ Given, se	ee immunization record	tered into WVSIIS
	Public 🗆 Well 🗆 Te			athroom and urinate by et or shirt by themselv	himself/herself □ Child es □ Child can eat	Referrals: □ Developmental □ Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498		
• • •	entation □ Yes □ N		independently ☐ Ch	ild can engage in ima	inative play ☐ Child can			
	pplied (apply every 3	•	play in cooperation and share ☐ Child can use 3 word sentences ☐ Child can speak in words that are 75% understandable to strangers			☐ Dental ☐ Vision ☐ Hearing ☐ Other		
☐ Yes ☐ No Vision Acuity Screen: R			□ Child can tell you a story from a book or TV □ Child can compare things using words like bigger or shorter □ Child can understand simple prepositions, such as on or under □ Child can pedal a tricycle □ Child can climb on and off couch or chair □ Child can jump			☐ Children with Special HealthCare Needs (CSHCN)		
Wears glasses? [□ Yes □ No		forward ☐ Child can draw a single circle ☐ Child can draw a person with head and 1 other body part ☐ Child can cut with child scissors					
Hearing Screen (Subjective screen required) Do you think your child hears okay? □ Yes □ No Wears hearing aids? □ Yes □ No			□ Concerns about child's speech, learning, or motor skills			Please Print Name of Facility or Clinician		
3						Signature of Clinici	an/Title	
			tion above this line is	intended to be rele	 ased to meet school ent	ry requirements		
Medical Histor	rv					Do you utilize a car/h	oooster seat for your child? □	Ves II No
☐ Initial Screen	☐ Periodic Scree	en	•	•	family needs daily and/or ☐ No	,	on/video game/internet/cell ph	
☐ Family health	history reviewed _		Hioritrily (1000, 1100s)	ng, neat, etc.)? Life:	□ NO			•
					e home? ☐ Yes ☐ No		[·] e you and your family under <u>n</u> □ Moderate □ Severe	<u>ow</u> ?
	e exposure □ Yes I		Child care/after schools your child in school			What kind of stress	? (✓ Check those that apply)	
•	-	vioral health services?					rtner, family and/or friends)	
□ Yes □ No			Any problems?			cual) □ Family member incard incial/money □ Emotional loss	erated Lack of	

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

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

☐ Scary experience that your child cannot forget_

☐ Has a firearm(s)/weapon(s)

☐ Threatened with violence/abuse

☐ Drugs (prescription or otherwise)_

☐ Access to firearm(s)/weapon(s)

☐ Witnessed violence/abuse

Psychosocial/Behavioral

What is your family living situation_

Family relationships ☐ Good ☐ Okay ☐ Poor



creen Date			3 Year Form, Page 2
Name		DOB	Age Sex: □ M □ F
Indicators of Serious Emotional or Behavioral	Nutrition/Physical	Activity/Sleen	Age Appropriate Health Education/Anticipatory
	Normal eating habits		
Disturbance (✓ Check those that apply)		an protein per day	Guidance (Consult Bright Futures, Fourth Edition. For further
If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/	☐ Vitamins		 information: https://brightfutures.aap.org) Social Determinants of Health, Playing with Siblings and Peers,
PGHN/help4wv-PCP-referral).	☐ Normal eliminatio	n	Social Determinants of Health, Playing with Sibilings and Peers, Encouraging Literacy Activities, Promoting Healthy Nutrition and
<u>РБПіўпеір4wv-РСР-гетета</u> ў.		exercise an hour most days	Physical Activity, and Safety
☐ Inappropriate behavior resulting in disruption to others or	Type of physical act	ivity/exercise	- ☐ Discussed ☐ Handouts Given
becoming known to supervisory staff		terns? ☐ Yes ☐ No	- Discussed Litratidodis Giveri
☐ Persistently uncooperative or disobedient with doing routine	Hours of sleep each	night?	
care tasks for the child (e.g., getting dressed, taking a bath,			Plan of Care
brushing teeth, age-appropriate bowel and urine habits)			Assessment
☐ Has been sexually inappropriate such that adults have		noglobin/Hematocrit)	☐ Well Child ☐ Other Diagnosis
concern about welfare of other children who may be around	☐ Low risk ☐ High	n risk	
the child unsupervised	*Lead Risk		
☐ Often mean and nasty to other people and animals	☐ Low risk ☐ High	n risk	Labs
☐ Persistently antagonizes other children (e.g., grabs others'	*Tuberculosis Risk		☐ Hemoglobin/hematocrit (if high risk)
toys, purposefully knocks over or damages others' toys,	☐ Low risk ☐ High		☐ Blood lead (if not completed at 12 and/or 24 months or high risk)
bullies, teases, shoves)		THOR	(enter into WVSIIS)
☐ Often plays alone even when there are opportunities for peer	*See Periodicity So	chedule for Risk Factors	☐ TB skin test (if high risk)
play, would rather be alone			□ Other
☐ Has emotional flare-ups frequently, but not most of the time	Physical Exami	nation (N=Normal, Abn=Abnormal)	
(e.g., sobbing uncontrollably, outbursts that are difficult to	General Appearance	e DN DAbn	
control or deflect)	Skin	□ N □ Abn	
□ Notable emotional restriction (e.g., has difficulty expressing	Neurological	□ N □ Abn	Referrals
strong emotions such as fear, hate, love)	Reflexes	□ N □ Abn	See page 1, school requirements
Non-accidental self-harm, mutilation, or injury which is not	Head	□ N □ Abn	
life-threating but not trivial (e.g., suicidal gestures or behavior	Neck	□ N □ Abn	Medical Necessity
without intent to die, cuts self) □ Frequent or strange or odd behavior (e.g., eats non-food	Eyes	□ N □ Abn	For treatment plans requiring authorization, please complete
items, smears feces)	Red Reflex	□ N □ Abn	page 3. Contact a HealthCheck Regional Program Specialist to
☐ Child's developmental needs cannot be adequately met	Ocular Alignment	□ N □ Abn	assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
because child's needs/developmental demands exceed	Ears	□ N □ Abn	-
family resources	Nose	□ N □ Abn	
laining resources	Oral Cavity/Throat	□ N □ Abn	Tonon ophical tion in your or ago
	Lung	□ N □ Abn	□ Other
	Heart	□ N □ Abn	
	Dulaga	□ N □ Abn	
	Abdomen	□ N □ Abn	☐ Screen has been reviewed and is complete
	Genitalia	□ N □ Abn	-
	Back	□ N □ Abn	See page 1, school requirements for required signature
	Hips	□ N □ Abn	
	Extremities	□ N □ Abn	

Possible Signs of Abuse/Neglect ☐ Yes ☐ No

Concerns and/or questions____

General Health

☐ Growth plotted on growth chart ☐ BMI calculated and plotted on BMI chart

Screen Date		West Virginia Department of Health and Human Resources Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen							orm
Name					DOB		Age	Sex: 🗆 M 🗆	1 F
Weight	Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (op	tional)	
Allergies □ NKI	DA								
Current meds] None								
☐ Foster Child _		☐ Kinship Placement		☐ Child with special he	alth care needs	□ IEP/se	ction 504 in place		
Accompanied by	/ □ Parent □ Grandpa	arent □ Foster parent □ F	oster organization						_
Current oral heal Water source Fluoride supplent Fluoride varnish Yes No Vision Acuity S R L Wears glasses? Hearing Screen 20 db@ R ear 500 L ear 500	Ith problems Public □ Well □ Test nentation □ Yes □ No applied (apply every 3 to creen: □ Yes □ No □ UTO (retest in 6 OHZ Rear 1000HZ	TO (retest in 6 months)	□ Child can enter be herself □ Child car undress without mu imaginative play □ speak in words that can draw pictures the when playing game. □ Child can skip on without support □ Child can draw a medium sized butto fingers instead of fis □ Concerns about of	rveillance (✓ Check the pathroom and have a bean brush his/her teeth to help □ Child can eare 100% understand the path of the	owel movement by himself, I Child can dress and ngage in well-developed ole questions Child can able to strangers Child can follow simple rules	□ UTD □ Given, so Referrals: □ Develoto □ Mental/behavioral □ Dental □ Vision □ Other □ Children with Spetimes 1-800-642-9704 □ Women, Infants at the second seco	health/trauma - Help4W Hearing HealthCare Needs (nd Children (WIC) 1-304 of Facility or Clinician	□ Entered into WVSII /V.com/1-844-435-7498 CSHCN) 1-558-0030	s
		The informat	ion above this line i	is intended to be rel	eased to meet school e	ntry requirements			
Medical Histo ☐ Initial Screen ☐ Family health	Dry ☐ Periodic Screen n history reviewed		Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No						
In utero substanc	ce exposure □ Yes □ I		, ,		de home? □ Yes □ No	□ None □ Slight I	re you and your family un ☐ Moderate ☐ Severe ☐ (✓ Check those that a		
☐ Yes ☐ No Recent injuries, s	• ,	ral health services? s to other providers and/or	Is your child in school? ☐ Yes ☐ NoFavorite thing about school			☐ Relationships (partner, family and/or friends) ☐ School/work ☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical.			of
hospitalizations:			Any problems? Activities outside sc						

Peer relationships/friends ☐ Good ☐ Okay ☐ Poor

☐ Scary experience that your child cannot forget_

☐ Drugs (prescription or otherwise) ☐ Access to firearm(s)/weapon(s)

☐ Witnessed violence/abuse

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

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

☐ Has a firearm(s)/weapon(s)

☐ Threatened with violence/abuse

Psychosocial/Behavioral

What is your family living situation_

Family relationships ☐ Good ☐ Okay ☐ Poor

Continue on page 2

insurance

Other



creen Date		4 Year Form, Page 2
Name	DOB	Age Sex: □ M □ F
Indicators of Serious Emotional or Behavioral Disturbance (✓ Check those that apply) If any indicator is selected, referral to the Children's Crisis	Nutrition/Physical Activity/Sleep Normal eating habits? □ Yes □ No Fruits/vegetables/lean protein per day	Age Appropriate Health Education/Anticipatory Guidance (Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org)
and Referral Line is recommended (https://hipaa.jotform.com/ PGHN/help4wv-PCP-referral).	□ Vitamins □ Normal elimination	 Social Determinants of Health, School Readiness, Developing Healthy Nutrition and Personal Habits, Media Use, and Safety
☐ Inappropriate behavior resulting in disruption to others or becoming known to supervisory staff	☐ Physical activity/exercise an hour most days Type of physical activity/exercise Normal sleeping patterns? ☐ Yes ☐ No	☐ Discussed ☐ Handouts Given
 □ Persistently uncooperative or disobedient with doing routine care tasks for the child (e.g., getting dressed, taking a bath, brushing teeth, age-appropriate bowel and urine habits) □ Has been sexually inappropriate such that adults have 	Hours of sleep each night? *Anemia Risk (Hemoglobin/Hematocrit) □ Low risk □ High risk	Plan of Care Assessment □ Well Child □ Other Diagnosis
concern about welfare of other children who may be around the child unsupervised Often mean and nasty to other people and animals Persistently antagonizes other children (e.g., grabs others' toys, purposefully knocks over or damages others' toys,	*Lead Risk Low risk High risk *Tuberculosis Risk Low risk High risk	Labs ☐ Hemoglobin/hematocrit (if high risk) ☐ Blood lead (if not completed at 12 and/or 24 months or high risk) (enter into WVSIIS) ☐ TB skin test (if high risk)
 bullies, teases, shoves) Often plays alone even when there are opportunities for peer play, would rather be alone 	*Dyslipidemia Risk □ Low risk □ High risk	☐ Lipid profile (if high risk) ☐ Other
☐ Has emotional flare-ups frequently, but not most of the time (e.g., sobbing uncontrollably, outbursts that are difficult to	*See Periodicity Schedule for Risk Factors	
control or deflect) Notable emotional restriction (e.g., has difficulty expressing strong emotions such as fear, hate, love)	Physical Examination (N=Normal, Abn=Abnormal) General Appearance □ N □ Abn Skin □ N □ Abn	
□ Non-accidental self-harm, mutilation, or injury which is not life-threating but not trivial (e.g., suicidal gestures or behavior	Neurological □ N □ Abn Reflexes □ N □ Abn Head □ N □ Abn	For treatment plans requiring authorization, please complete
without intent to die, cuts self) Frequent or strange or odd behavior (e.g., eats non-food items, smears feces)	Neck □ N □ Abn Eyes □ N □ Abn	assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
☐ Child's developmental needs cannot be adequately met because child's needs/developmental demands exceed family resources	Red Reflex □ N □ Abn Ocular Alignment □ N □ Abn Ears □ N □ Abn	Follow Up/Next Visit □ 5 years of age □ Other
	Nose	☐ Screen has been reviewed and is complete
	Heart □ N □ Abn Pulses □ N □ Abn Abdomen □ N □ Abn	See page 1, school requirements for required signature

□ N □ Abn _____

Possible Signs of Abuse/Neglect ☐ Yes ☐ No

Genitalia

Extremities

Back Hips

General Health

- ☐ Growth plotted on growth chart
- ☐ BMI calculated and plotted on BMI chart

Screen Date		Early and Periodic S			alth and Human Resourc PSDT) HealthCheck Prog		1th Screen 5 and 6 \		ar Form	
Name				· · · · · · · · · · · · · · · · · · ·	DOB		Age	Sex: □ M	□F	
Weight	Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (op	tional)		
Allergies ☐ NKD	DA									
Current meds □	l None									
☐ Foster Child _		☐ Kinship Placement		☐ Child with special he	ealth care needs		P/section 504 in place			
Accompanied by	⊓ Parent □ Grand	dparent □ Foster parent □	Foster organization							
Oral Health Date of last dental visit		☐ Child can balanc ☐ Child is able to ti person with at least and is able to copy ☐ Child has good a sentences, uses ap and names at least ☐ Child follows sim undresses and dres ☐ Concerns about	e on one foot, hops and e a knot, has mature pot 6 body parts, prints so squares and triangles articulation, tells a simple propriate tenses and p 4 colors	d skips encil grasp, can draw a ome letters and numbers le story using full ronouns, can count to 10, o listen and attend, and tance	Immunizations: Attach current immunization record ☐ UTD ☐ Given, see immunization record ☐ Entered into WVSIIS Referrals: ☐ Developmental ☐ Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498 ☐ Dental ☐ Vision ☐ Hearing ☐ Other ☐ Children with Special HealthCare Needs (CSHCN) 1-800-642-9704 Please Print Name of Facility or Clinician Signature of Clinician/Title					
L ear 500F	HZ Lear1000 ds? □ Yes □ No	DHZ 2000HZ 4000HZ 4000HZ 4000HZ 4000HZ 4000HZ 4000HZ	tion above this line i		eased to meet school end c family needs daily and/or s □ No	try requirements Do you utilize a car/b Does your child wea	pooster seat for your chil r protective gear, includi		>	
	☐ Initial Screen ☐ Periodic Screen ☐ Family health history reviewed			Are you and/or your partner working outside home? Child care/after school care Child's grade in school Favorite subject Any problems? Activities outside school			 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, 			
Child currently red ☐ Yes ☐ No										
•		•	Peer relationships/friends □ Good □ Okay □ Poor			emotional and/or sexual) □ Family member incarcerated □ Lack o support/help □ Financial/money □ Emotional loss □ Health				

Child exposed to ☐ Cigarettes ☐ E-Cigarettes/Vaping ☐ Alcohol

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

☐ Scary experience that your child cannot forget_

☐ Has a firearm(s)/weapon(s)

☐ Threatened with violence/abuse

☐ Drugs (prescription or otherwise)_

☐ Access to firearm(s)/weapon(s)

☐ Witnessed violence/abuse

Psychosocial/Behavioral

What is your family living situation

Family relationships ☐ Good ☐ Okay ☐ Poor

Continue on page 2

insurance ☐ Other



lame		DOB	Age Sex: □ M □ F
Indicators of Serious Emotional or Behavioral	Nutrition/Physical	Activity/Sleep	Age Appropriate Health Education/Anticipatory
Disturbance (✓ Check those that apply)	Normal eating habits	• •	Guidance (Consult Bright Futures, Fourth Edition. For further
If any indicator is selected, referral to the Children's Crisis	Fruits/vegetables/lea	an protein per day	information: https://brightfutures.aap.org)
and Referral Line is recommended (https://hipaa.jotform.com/			
PGHN/help4wv-PCP-referral).		n	School, Physical Growth and Development and Safety
FGHIV/Help4wv-PCF-Teterral).	☐ Physical activity/e	exercise an hour most days	☐ Discussed ☐ Handouts Given
☐ Does not achieve satisfactorily due to poor attention or high		vity/exercise	☐ Discussed ☐ Haildouts Given
activity level; special accommodations are needed or		terns? Yes No	
implemented		night?	Plan of Care
☐ Persistently uncooperative or disobedient with doing routine			——— Train or ourc
care tasks for the child (e.g., getting dressed, taking a bath,	*Anemia Risk (Hemo		Assessment
brushing teeth, age-appropriate bowel and urine habits)	☐ Low risk ☐ High	ı risk	□ Well Child □ Other Diagnosis
☐ On more than one occasion, committed acts that would be	*Lead Risk		Laba
considered delinquent if a child were older (e.g., vandalism,	☐ Low risk ☐ High	n risk	Labs
defacing property, threatening aggression, shoplifting other			☐ Hemoglobin/hematocrit (if high risk)
than minor items such as candy)	*Tuberculosis Risk		☐ Blood lead (if not completed at 12 and/or 24 months or high risk)
☐ Repeatedly and intentionally plays with fire such that	☐ Low risk ☐ High	n risk	(enter into WVSIIS)
damage to property or person could result	*Dyslipidemia Risk (vear 6)	☐ TB skin test (if high risk)
☐ Often mean and nasty to other people and animals	□ Ĺow≀risk □ High		☐ Lipid profile (year 6, if high risk)
☐ Persistently antagonizes other children (e.g., grabs others'	*0 Dili-it O-l	and the four Birds Fourteen	□ Other
toys, purposefully knocks over or damages others' toys,	"See Periodicity Scr	edule for Risk Factors	
bullies, teases, shoves)			
☐ Often plays alone even when there are opportunities for peer	Physical Exami	nation (N=Normal, Abn=Abnormal)	Referrals
play, would rather be alone		e □ N □ Abn	
☐ Extremely tense or fearful (e.g., overreacts to sounds and	Skin	□N □ Abn	
noises)	Neurological	□ N □ Abn	Medical Necessity:
☐ Persistent self-criticism or feelings of worthlessness	Reflexes	□N □ Abn	For treatment plans requiring authorization, please complete
☐ Non-accidental self-harm, mutilation, or injury which is not	Head	□ N □ Abn	page 3. Contact a HealthCheck Regional Program Specialist for
life-threatening but not trivial (e.g., suicidal gestures or	Neck	□ N □ Abn	assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
behavior without intent to die, cuts self)	Eyes	□ N □ Abn	
☐ Frequent or strange or odd behavior (e.g., eats non-food	Ocular Alignment	□ N □ Abn	
items, smears feces)	Ears	□ N □ Abn	Follow Up/Next Visit □ 6 years of age □ 7 years of age
☐ Extremely limited in expressing self verbally and this is not	Nose	□ N □ Abn	
due to any know physical or sensory disability, speech	Oral Cavity/Throat	□ N □ Abn	
impediment or lack of familiarity with English	Lung	□ N □ Abn	
☐ Child's developmental needs cannot be adequately met	Heart	□ N □ Abn	☐ Screen has been reviewed and is complete
because child's needs/developmental demands exceed	Pulses	□ N □ Abn	
family resources	Abdomen	□ N □ Abn	
·	Genitalia	□ N □ Abn	See page 1 school requirements for required signature
	Back	□ N □ Abn	
	Hips	□ N □ Abn	
	Extremities	□ N □ Abn	

Possible Signs of Abuse /Neglect ☐ Yes ☐ No

General Health

П	Growth	plotted	οn	arowth	chart

☐ BMI calculated and plotted on BMI chart

	Health.
MCFH/HC 11-2021	Human Resources BUREAU FOR PUBLIC HEALTH

Screen Date Early and Periodic S	West Virginia Department of Health and Human Resourc creening, Diagnosis, and Treatment (EPSDT) HealthCheck Prog		7 and 8 Year Form	
Name	DOB	Age	Sex: 🗆 M 🗆 F	
Weight Height BMI	Pulse BP Resp	Temp Pulse Ox (option	al)	
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 ☐ F	oster organization	☐ Other		
Immunizations: Attach current immunization record □ UTD □ Given, see immunization record □ Entered into WVSIIS Oral Health	Hearing Screen 20 db@ R ear 500HZ R ear 1000HZ 2000HZ 4000HZ L ear 500HZ L ear 1000HZ 2000HZ 4000HZ		om/1-844-435-7498	
Date of last dental visit	Wears hearing aids? ☐ Yes ☐ No	☐ Children with Special HealthCare Needs (CSF 1-800-642-9704	HCN)	
Water source □ Public □ Well □ Tested Fluoride supplementation □ Yes □ No	☐ Developmental Surveillance Concerns about child's speech, learning, or motor skills	1-000-042-9704		
Vision Acuity Screen:		Please Print Name of Facility or Clinician		
Wears glasses? ☐ Yes ☐ No		Signature of Clinician/Title		
The information Medical History □ Initial Screen □ Periodic Screen	above this line is intended to be released to meet school entry. Are parents/caregivers working outside home? □ Yes □ No Child care/after school care	requirements How much stress are you and your family under □ None □ Slight □ Moderate □ Severe What kind of stress? (✓ Check those that apply		
☐ Family health history reviewed	Grade in school	☐ Relationships (partner, family and/or friends) ☐ School/work		
Currently receiving mental/behavioral health services? ☐ Yes ☐ No	Favorite subject	☐ Child care ☐ Drugs ☐ Alcohol ☐ Violence/a emotional and/or sexual) ☐ Family member inca support/help ☐ Financial/money ☐ Emotional lo	arcerated □ Lack of oss □ Health	
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:	Peer relationships/friends □ Good □ Okay □ Poor	insurance ☐ Other		
	Exposure to □ Cigarettes □ E-Cigarettes/Vaping □ Alcohol □ Drugs (prescription or otherwise) □ Access to firearm(s)/weapon(s) □ Has a firearm(s)/weapon(s)			
Psychosocial/Behavioral What is your family living situation	Are the firearm(s)/weapon(s) secured? ☐ Yes ☐ No ☐ NA ☐ Witnessed violence/abuse ☐ Threatened with violence/abuse ☐ Scary experience that your child cannot forget			
Family relationships ☐ Good ☐ Okay ☐ Poor Do you have concerns about meeting basic family needs daily and/or monthly (food, housing, heat, etc.)? ☐ Yes ☐ No	Does your child wear protective gear, including seat belts? ☐ Yes ☐ No ☐ Excessive television/video game/internet/cell phone use			
		Continue on page 2		

West Virginia Department of Health and Human Resources

creen Date			/ ai	nd 8 Year Form, Page
Name		DOB	Age	Sex: 🗆 M 🗆 F
Indicators of Serious Emotional or Behavioral	☐ Normal elimination	1	Age Appropriate Health Education/	Anticipatory
Disturbance (✓ Check those that apply)		xercise an hour most days	Guidance (Consult Bright Futures, Fourth	Edition. For further
If any indicator is selected, referral to the Children's Crisis	Type of physical acti	vity/exercise	information: https://brightfutures.aap.org)	
and Referral Line is recommended (https://hipaa.jotform.com/		erns? ☐ Yes ☐ No	Social Determinants of Health, Development	al and Mental Health.
PGHN/help4wv-PCP-referral).	Hours of sleep each	night?	School, Physical Growth and Development, a	
<u> </u>			☐ Discussed ☐ Handouts Given	
☐ Does not achieve satisfactorily due to poor attention or high	*Anomia Diak (Ham	a alah in/l lamata arit\		
activity level; special accommodations are needed or	□ Low risk □ High	oglobin/Hematocrit)	Diam of Core	
implemented		Tion	Plan of Care	
☐ Inappropriate behavior resulting in disruption to others	*Tuberculosis Risk		Assessment	
☐ Deliberate damage to home	☐ Low risk ☐ High	risk	☐ Well Child ☐ Other Diagnosis	
☐ On more than one occasion, committed acts that would be	*Dyslipidemia Risk			
considered delinquent if child were older (e.g., vandalism,	☐ Low risk ☐ High	risk	Labs	
defacing property, threatening aggression, shoplifting other			☐ Hemoglobin/hematocrit (if high risk)	
than minor items such as candy)	*See Periodicity Sc	hedule for Risk Factors	☐ TB skin test (if high risk)	
☐ Repeatedly and intentionally plays with fire such that			☐ Lipid profile (if high risk)	
damage to property or person could result	Physical Examir	nation (N=Normal, Abn=Abnormal)	□ Other	
☐ Often mean or nasty to other people and animals		□ N □ Abn		
☐ Persistently antagonizes other children (e.g., grabs others'	Skin	□ N □ Abn		
toys, purposefully knocks over or damages others' toys,	Neurological	□ N □ Abn	Referrals	
bullies, teases, shoves)	Reflexes	□ N □ Abn		
☐ Often plays alone even when there are opportunities for peer	Head	□ N □ Abn	. •	
play; would rather be alone	Neck	□ N □ Abn		
☐ Extremely tense or fearful (e.g., overreacts to sounds or	Eyes	□ N □ Abn	Medical Necessity:	
noises)	Ears	□ N □ Abn	For treatment plans requiring authorization	
☐ Persistent self-criticism or feeling of worthlessness	Nose	□ N □ Abn	page 3. Contact a HealthCheck Regional F	Program Specialist for
☐ Talks or repeatedly thinks about harming self, killing self, or	Oral Cavity/Throat	□ N □ Abn	assistance at 1-800-642-9704 or dhhr.wv.g	ov/healthcheck.
wanting to die	Lung	□ N □ Abn		
☐ Pre-occupying cognitions or fantasies with bizarre, odd, or	Heart	□ N □ Abn		
gross themes	Pulses	□ N □ Abn	Follow Up/Next Visit □ 8 years of age □	0 years of ago
☐ Youth's developmental needs cannot be adequately met	Abdomen	□ N □ Abn		
because youth's needs/developmental demands exceed	Genitalia	□ N □ Abn	□ Other	
family resources.	Back	□ N □ Abn		
	Hips	□ N □ Abn	Coreen has been reviewed and in	
General Health	Extremities	□ N □ Abn	☐ Screen has been reviewed and is	Scomplete
☐ Growth plotted on growth chart				
□ BMI calculated and plotted on BMI chart	Possible Signs of A	lbuse/Neglect ☐ Yes ☐ No		

☐ BMI calculated and plotted on BMI chart

Fruits/vegetables/lean protein per day_____

Nutrition/Physical Activity/Sleep Normal eating habits? ☐ Yes ☐ No

☐ Vitamins_

See page 1, school requirements for required signature

Screen Date		Early and Periodic S			alth and Human Resource PSDT) HealthCheck Prog		th Screen	9 and 10 Year Form
Name					DOB		Age	Sex: 🗆 M 🗆 F
Weight	Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (opt	ional)
Allergies □ NKD	DA							
Current meds □	l None							
☐ Foster Child _		□ Kinship Placement		□ Child with special	health care needs	D IE	P/section 504 in place_	
Accompanied by	□ Parent □ Grandpa	rent □ Foster parent □ F	oster organization			□ Other		
Medical Histo ☐ Initial Screen	Periodic screen		Concerns about sp	eech, learning, social o	r motor skills	☐ Frequent use of p	orofane, vulgar, or curse	words to household
	history reviewed		Concerns about depression and/or anxiety			 □ Deliberate damage to home □ Frequently truant (i.e., approximately once every 2 weeks or for several consecutive days) 		
Currently receiving mental/behavioral health services? ☐ Yes ☐ No			*Positive screen = numbered responses 4 or greater			☐ Marked changes in moods that are generally intense and abrupt☐ Friendships change to mostly substance users		
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:		Feelings over the past 2 weeks: (✓ Check one for each question) Repeated, disturbing memories, thoughts, or images of a stressful experience from the <u>past</u> ? □ Not at all (0) □ A little bit (1) □ Moderately (2) □ Quite a bit (3) □ Extremely (4)			 □ Preoccupying cognitions or fantasies with bizarre, odd, or gross themes □ Currently at risk of confinement because of frequent or serious violations of law 			
Psychosocial What is your fami	I/Behavioral ily living situation		Feeling very upset when something reminded you of a stressful experience from the <u>past</u> ? Not at all (0) Moderately (2) Quite a bit (3) Extremely (4)			☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources		
			How much stress	are you and your family	under now ?	General Health		
Do you have cond	lips □ Good □ Okay □ cerns about meeting bas busing, heat, etc.)? □ Ye	sic family needs daily and/or	☐ None ☐ Slight What kind of stres	☐ Moderate ☐ Seven	e t apply)	☐ Growth plotted on growth chart ☐ BMI calculated and plotted on BMI chart		
				artner, family and/or frie ol □ Violence/abuse (p	ends) □ School/work nysical, emotional and/or	Nutrition/Physical Activity/Sleep		
	givers working outside he chool care		,	member incarcerated ☐ otional loss ☐ Health i	• • • • • • • • • • • • • • • • • • • •	Normal eating habits Fruits/vegetables/lea	? ⊔ Yes ⊔ No n protein per day	
Grade in school			☐ Other	Ottoriai ioss 🗖 i leatti ii	isurance	☐ Vitamins ☐ Normal elimination		
Favorite subject							rercise an hour most day	/S
Any problems?						Type of physical activ		
Activities outside			Indicators of S	erious Emotional o	or Behavioral		erns? ☐ Yes ☐ No	
Peer relationships/friends ☐ Good ☐ Okay ☐ Poor		Disturbance (✓ Check those that apply)			Hours of sleep each night?			
			•	•	e Children's Crisis and			
•	Cigarettes ☐ E-Cigaret	. •		•	paa.jotform.com/PGHN/	Oral Health		
J (ption or otherwise)		help4wv-PCP-refer	<u>ral</u>).		Date of last dental vis	sit	
☐ Access to firea	arm(s)/weapon(s)	Has a firearm(s)/weapon(s)				Current oral health p	roblems	

- ☐ Talks or repeatedly thinks about harming self, killing self, or wanting to die
- ☐ Frequently mean to other people or animals

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

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

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

☐ Threatened with violence/abuse

☐ Witnessed violence/abuse

- ☐ 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)

Current oral health problems Water source ☐ Public ☐ Well ☐ Tested

Fluoride supplementation ☐ Yes ☐ No

Vision Acuity Screen: (Objective 10 years)

Wears glasses? ☐ Yes ☐ No



C	Data		
Screen	Date		

9 and 10 Year Form, 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	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	Plan of Care Assessment Well Child Other Diagnosis Immunizations UTD Given, see immunization record Entered into WVSIIS
*Anemia Risk (Hemoglobin/Hematocrit) □ Low risk □ High risk		Labs
*Tuberculosis Risk □ Low risk □ High risk	Questions/Concerns/Notes	 ☐ Hemoglobin/hematocrit (if high risk) ☐ TB skin test (if high risk) ☐ Fasting lipoprotein (once between 9 and 11 years and/or high
*Dyslipidemia Risk □ Low risk □ High risk Fasting lipoprotein required once between 9 and 11 years		risk) □ Other
*See Periodicity Schedule for Risk Factors		
Physical Examination (N=Normal, Abn=Abnormal) General Appearance □ N □ Abn		Referrals ☐ Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498 ☐ Dental ☐ Vision ☐ Hearing ☐ Other
Neurological □ N □ Abn Reflexes □ N □ Abn Head □ N □ Abn Neck □ N □ Abn Eyes □ N □ Abn		☐ Children with Special HealthCare Needs (CSHCN) 1-800-642-9704
Ears		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.
Pulses □ N □ Abn Abdomen □ N □ Abn Genitalia □ N □ Abn Back □ N □ Abn		Follow Up/Next Visit □ 10 years of age □ 11 years of age □ Other
Hips		C Serven has been reviewed and in complete
LMP □ Regular □ Irregular Bleeding □ Normal □ Heavy Cramping □ No □ Slight □ Severe		☐ Screen has been reviewed and is complete
Possible Signs of Abuse/Neglect ☐ Yes ☐ No		Please Print Name of Facility or Clinician
	-	Signature of Clinician/Title

Screen Date		Early and Periodic So	West Virginia Department of Health and Human Resource creening, Diagnosis, and Treatment (EPSDT) HealthCheck Progr						Form
Name					DOB		Age	Sex: □ M	ΠF
Weight	Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (or	otional)	
Allergies □ NKD	A								
Current meds □	None								
☐ Foster Child		□ Kinship Placement_		□ Child with spe	cial health care needs	☐ IEP/section 504 in place			
Accompanied by	☐ Parent ☐ Grandpar	rent □ Foster parent □ F	oster organization_	· · · · · · · · · · · · · · · · · · ·					
Immunizations: Attach current immunization record □ UTD □ Given, see immunization record □ Entered into WVSIIS Oral Health Date of last dental visit □ Current oral health problems □ Water source □ Public □ Well □ Tested Fluoride supplementation □ Yes □ No			Hearing Screen (Objective, once between 11 and 14 years) 20db@ R ear:500HZ1000HZ2000HZ4000HZ L ear:500HZ1000HZ2000HZ4000HZ R ear:6000HZ8000HZ L ear:6000HZ8000HZ Wears hearing aids? □ Yes □ No			Referrals: Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498 Substance abuse - Help4WV.com/1-844-435-7498 Dental Vision Hearing Other Family Planning Program (FPP) 1-800-642-9704 Children with Special HealthCare Needs (CSHCN) 1-800-642-9704			98
Vision Acuity Screen: (Objective 12 years) RLL		☐ Developmental Surveillance Concerns about speech, learning, social and/or motor skills			Please Print Name of Facility or Clinician				
vvears glasses? L	Wears glasses? □ Yes □ No						Signature of Clinician/Title		
	. – – – – –	The information	above this line is	s intended to be releas	sed to meet school entry	requirements			>
☐ Initial Screen	Medical History □ Initial Screen □ Family health history reviewed			Any problems Activities outside school Peer relationships/friends Good Okay Poor *Tobacco use Gigarettes # per day Traumatic Stress Reactions/PCL-C *Positive screen = numbered response Feelings over the past 2 weeks: (Che Repeated, disturbing memories, thoughts				k one for each questic	on)
Currently receiving mental/behavioral health services? ☐ Yes ☐ No			☐ E-Cigarettes/Vaping ☐ *Chew ☐ Passive Smoke Risk			stressful experience from the <u>past</u> ? \(\text{Not at all (0)} \) \(\text{A little bit} \) \(\text{Moderately (2)} \) \(\text{Quite a bit (3)} \) \(\text{Extremely (4)} \) \(Feeling very upset when something reminded you of a stressful \)			oit (1)
	t injuries, surgeries, illnesses, visits to other providers and/or alizations:			*If positive see Periodicity Schedule for links to CRAFFT and /or SBIRT screening tools			experience from the <u>past</u> ? ☐ Not at all (0) ☐ A little bit (1) ☐ Moderately (2) ☐ Quite a bit (3) ☐ Extremely (4)		
Psychosocial/Behavioral What is your family living situation			□ 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 □ Pepression Screen/Patient Health Questi *Positive screen = numbered responses *If Positive see Periodicity Schedule for I Feelings over the past 2 weeks: (✓ Check Little interest or pleasure in doing things: □			3 or greater ink to PHQ-9	on)		
Family relationships II Cood II Okay II Door						Little interest or pleasure in doing things: Not at all (0)			,

Are you in a relationship? ☐ Yes (☐ Male ☐ Female) ☐ No

Are you sexually active? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No _____

(13 and 14 years)

Method of contraception

Family relationships ☐ Good ☐ Okay ☐ Poor

Child care/after school care

Grade in school Favorite subject_

monthly (food, housing, heat, etc.)? ☐ Yes ☐ No _

Do you have concerns about meeting basic family needs daily and/or

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

Continue on page 2



 \square Several days (1) \square More than $\frac{1}{2}$ the days (2) \square Nearly every day (3)

 \square Several days (1) \square More than $\frac{1}{2}$ the days (2) \square Nearly every day (3)

Feeling down, depressed, or hopeless: ☐ Not at all (0)

creen Date		11, 12, 13 and 14 Year Form, Page	
Name_	DOB	Age Sex: □ M □ F	
How much stress are you and your family under <u>now</u> ? □ None □ Slight □ Moderate □ Severe What kind of stress? (✓ Check those that apply)	□ Vitamins Normal elimination	Possible Signs of Abuse/Neglect □ Yes □ No	
☐ 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	☐ Physical activity/exercise an hour most days Type of physical activity/exercise Normal sleeping patterns? ☐ Yes ☐ No Hours of sleep each night?	Age Appropriate Health Education/Anticipatory	
Other	*Anemia Risk (Hemoglobin/Hematocrit) □ Low risk □ High risk *Tuberculosis Risk	Guidance (Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org) Social Determents of Health, Physical Health and Health Promotion,	
Indicators of Serious Emotional or Behavioral Disturbance (✓ Check those that apply)	□ Low risk □ High risk	Emotional Well-Being, Risk Reduction and Safety ☐ Discussed ☐ Handouts Given	
If any indicator is selected, referral to the Children's Crisis and Referral Line is recommended (https://hipaa.jotform.com/PGHN/help4wv-PCP-referral).	*Dyslipidemia Risk □ Low risk □ High risk Fasting lipoprotein required once between 9 and 11 years *STI Risk	Plan of Care Assessment □ Well Child Visit □ Other Diagnosis	
 □ Talks or repeatedly thinks about harming self, killing self, or wanting to die □ Frequently mean to other people or animals 	□ Low risk □ High risk *HIV Risk □ Low risk □ High risk	Labs ☐ Hemoglobin/hematocrit (if high risk) ☐ TB skin test (if high risk)	
☐ Family conflict is pervasive and continual (characterized by hostility, tension, and/or scapegoating, etc.)	*See Periodicity Schedule for Risk Factors	☐ Fasting lipoprotein (once between 9 and 11 years and/or high risk)	
☐ Behavior frequently typically inappropriate and causes problems for self or others (i.e., fighting, belligerency, promiscuity)	Physical Examination (N=Normal, Abn=Abnormal) General Appearance □ N □ Abn	☐ STI test (if sexually active and/or high risk) ☐ HIV test (if sexually active and/or high risk)	
☐ Frequent use of profane, vulgar, or curse words to household members	Skin □ N □ Abn Neurological □ N □ Abn	_	
☐ Deliberate damage to home ☐ Frequently truant (i.e., approximately once every 2 weeks or	Reflexes □ N □ Abn Head □ N □ Abn Neck □ N □ Abn	See page 1, school requirements	
for several consecutive days) ☐ Marked changes in moods that are generally intense and abrupt	Eyes □ N □ Abn	For treatment plans requiring authorization, please comple	
 □ Friendships change to mostly substance users □ Preoccupying cognitions or fantasies with bizarre, odd, or gross themes 	Nose □ N □ Abn Oral Cavity/Throat □ N □ Abn Lung □ N □ Abn	assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.	
☐ Currently at risk of confinement because of frequent or serious violations of law	Heart □ N □ Abn Pulses □ N □ Abn	☐ 14 years of age ☐ 15 years of age	
☐ Youth's developmental needs cannot be adequately met because youth's needs/developmental demands exceed family resources	Abdomen □ N □ Abn Genitalia □ N □ Abn Back □ N □ Abn Hips □ N □ Abn		
General Health	Extremities	_	
☐ Growth plotted on growth chart ☐ BMI calculated and plotted on BMI chart	If female: LMP □ Regular □ Irregular Bleeding □ Normal □ Heavy	See page 1, school requirements for required signature	
Nutrition/Physical Activity/Sleen	Cramping ☐ No ☐ Slight ☐ Severe		

Nutrition/Physical Activity/Sleep Normal eating habits? ☐ Yes ☐ No Fruits/vegetables/lean protein per day_

Screen Date	Early and Periodic			alth and Human Resourd PSDT) HealthCheck Prog		th Screen	15, 16 and 17 Year For	
Name				DOB		Age	Sex: 🗆 M 🗆 F	
	jht BMI							
Allergies □ NKDA								
Current meds ☐ None								
☐ Foster Child	☐ Kinship Placement		☐ Child with special health care needs			☐ IEP/section 504 in place		
Accompanied by □ N/A □ Pa	arent □ Grandparent □ Foster par	ent □ Foster organizati	ion		□ Othe	r		
Oral Health Date of last dental visit Current oral health problems Water source Public W Fluoride supplementation Y Vision Acuity Screen: (Object	Entered into WVSII:	Hearing Screen (Objective, once between 15 and 17 years) 20db@ R ear:500HZ1000HZ2000HZ4000HZ L ear:500HZ1000HZ2000HZ4000HZ R ear:6000HZ8000HZ L ear:6000HZ8000HZ Wears hearing aids? □ Yes □ No □ Developmental Surveillance Concerns about speech, learning, social and/or motor skills			Referrals: Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498 Substance abuse - Help4WV.com/1-844-435-7498 Dental Vision Hearing Other Family Planning Program (FPP) 1-800-642-9704 Children with Special HealthCare Needs (CSHCN) 1-800-642-9704 Please Print Name of Facility or Clinician			
Wears glasses? □ Yes □ No					Signature of Clinician/Title			
	The informati	on above this line is in	tended to be relea	sed to meet school entry	requirements			
Medical History □ Initial Screen □ Periodic screen □ Family health history reviewed		What interests do you have outside of school and/or work?				numbered responses	4 or greater ck one for each question)	
	navioral health services? ☐ Yes ☐ No	□ *Tobacco use □ Cigarettes # per day □ E-Cigarettes/Vaping □ *Chew □ Passive Smoke Risk □ *Alcohol use			Repeated, disturbing memories, thoughts, or images of a stressful experience from the <u>past</u> ? Not at all (0) A little bit (1) Moderately (2) Quite a bit (3) Extremely (4)			
Recent injuries, surgeries, illne nospitalizations:	esses, visits to other providers and/or	□ *Drug use (prescription or otherwise) *If positive see Periodicity Schedule for links to CRAFFT and /or SBIRT screening tools			experience from the	hen something remind∘ past ? □ Not at all (0) l Quite a bit (3) □ Ext	☐ A little bit (1)	
Psychosocial/Behaviora What is your living situation?		□ 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			Depression Screen/Patient Health Questionnaire (PHQ-2) *Positive screen = numbered responses 3 or greater *If Positive see Periodicity Schedule for link to PHQ-9 Feelings over the past 2 weeks: (✓ Check one for each question)			
Do you have concerns about y	your family meeting basic needs daily , heat, etc.)? ☐ Yes ☐ No		. ,	,	Little interest or pleasure in doing things: ☐ Not at all (0) ☐ Several days (1) ☐ More than ½ the days (2) ☐ Near Feeling down, depressed, or hopeless: ☐ Not at all (0)			

Are you sexually active? $\ \square$ Yes $\ \square$ No

Do you have children? ☐ Yes ☐ No _____

Method of contraception _

Are you still in school? ☐ Yes ☐ No Working? ☐ Yes ☐ No

What are your future plans?____

Continue on page 2



Feeling down, depressed, or hopeless: ☐ Not at all (0)

 \square Several days (1) \square More than $\frac{1}{2}$ the days (2) \square Nearly every day (3)

Screen Date		15, 16 and 17 Year Form, Page
Name_	DOB	Age Sex: □ M □ F
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	□ 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? *Anemia Risk (Hemoglobin/Hematocrit) □ Low risk □ High risk	Guidance (Consult Bright Futures, Fourth Edition. For further information: https://brightfutures.aap.org) Social Determinants of Health, Physical Health and Health Promotion, Emotional Well-Being, Risk Reduction, and Safety □ Discussed □ Handouts Given
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).	*Tuberculosis Risk Low risk High risk *Dyslipidemia Risk Low risk High risk Fasting lipoprotein required once between 17 and 20 *STI Risk	☐ TB skin test (if high risk)
 □ 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 	□ Low risk □ High risk *HIV Risk □ Low risk □ High risk HIV test required once between 15 and 18 years *See Periodicity Schedule for Risk Factors	☐ Fasting lipoprotein (once between 17 and 20 years and/or high risk) ☐ STI test (if sexually active and/or high risk) ☐ HIV test (once between 15 and 18 years, if sexually active and/or high risk) ☐ Other
problems for self or others (i.e., fighting, belligerency, promiscuity) ☐ Frequent use of profane, vulgar, or curse words to household members	Physical Examination (N=Normal, Abn=Abnormal) General Appearance □ N □ Abn Skin □ N □ Abn Neurological □ N □ Abn	See page 1, school requirements
 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 	Reflexes □ N □ Abn Head □ N □ Abn Neck □ N □ Abn Eyes □ N □ Abn Ears □ N □ Abn	Medical Necessity For treatment plans requiring authorization, please complet page 3. Contact a HealthCheck Regional Program Specialist for a special section of 4,800,643,0704 or debt page 200,000 per page 200
 □ Friendships change to mostly substance users □ Preoccupying cognitions or fantasies with bizarre, odd, or gross themes 	Nose □ N □ Abn Oral Cavity/Throat □ N □ Abn Lung □ N □ Abn	Follow Up/Next Visit 16 years of age 17 years of age
 □ Currently at risk of confinement because of frequent or serious violations of law □ Youth's developmental needs cannot be adequately met 	Heart □ N □ Abn Pulses □ N □ Abn Abdomen □ N □ Abn	
because youth's needs/developmental demands exceed family resources	Genitalia □ N □ Abn Back □ N □ Abn	
General Health ☐ Growth plotted on growth chart	Hips	See page 1, school requirements for required signature

□ Regular □ Irregular

□ Normal □ Heavy

Possible Signs of Abuse/Neglect ☐ Yes ☐ No

□ No □ Slight □ Severe

If female:

LMP

Bleeding

Cramping

☐ BMI calculated and plotted on BMI chart

Nutrition/Physical Activity/Sleep

Normal eating habits? ☐ Yes ☐ No Fruits/vegetables/lean protein per day_

Screen Date		Early and Periodic So	West Virginia Department of Health and Human Resources Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen					18, 19 and 20 Year Form	
Name					DOB		Age	Sex: 🗆 M 🗆 F	
Weight	Height	BMI	Pulse	BP	Resp	Temp	Pulse Ox (o	ptional)	
Allergies □ NKI	DA							· · · · · · · · · · · · · · · · · · ·	
Current meds] None			· · · · · · · · · · · · · · · · · · ·					
☐ Child with spe	ecial health care needs_				☐ IEP/section 504 in p	ace			
Accompanied by	y □ N/A □ Parent □	Grandparent □ Other							
Medical History □ Initial Screen □ Periodic screen □ Family health history reviewed			Are you in a relationship Are you sexually active? Method of contraception Do you have children?	? ☐ Yes ☐ No	e □ Female) □ No	Disturbance (/ 0	•	e Children's Crisis and	
Currently receiving mental/behavioral health services? ☐ Yes ☐ No			Kelei				Referral Line is recommended (help4wv-PCP-referral).		
Recent injuries, surgeries, illnesses, visits to other providers and/or hospitalizations:			*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 ctrooofil experience from the past 2				nals al (characterized by		
Psychosocial/Behavioral What is your living situation		□ Moderately (2) □ Quite a bit (3) □ Extremely (4) Feeling very upset when something reminded you of a stressful experience from the <u>past</u> ? □ Not at all (0) □ A little bit (1) □ Moderately (2) □ Quite a bit (3) □ Extremely (4)			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				
		ol □ College/vocational	, ,	. ,	, ,	members ☐ Deliberate damae	ge to home		
Working?		Depression Screen/Patient Health Questionnaire (PHQ-2) *Positive screen = numbered responses 3 or greater *If Positive see Periodicity Schedule for link to PHQ-9 Feelings over the past 2 weeks: (Check one for each question)			☐ Frequently truant (i.e., approximately once every 2 weeks or for several consecutive days)				
					☐ Marked changes in moods that are generally intense and abrupt				
•	Do you have concerns about meeting basic family needs daily and/or nonthly (food, housing, heat, etc.)? Yes No		Little interest or pleasure in doing things: ☐ Not at all (0) ☐ Several days (1) ☐ More than ½ the days (2) ☐ Nearly every day (3)			 □ 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 			
□ *Tobacco use □ Cigarettes # per day □ E-Cigarettes/Vaping □ *Chew □ Passive Smoke Risk □ *Alcohol use		☐ Nearly every day (3)	☐ More than ½ t	· ,	violations of law ☐ Youth's developm	nental needs cannot be	adequately met because exceed family resources		
□ *Drug use (pre	escription or otherwise)_ Periodicity Schedule for		How much stress are year None ☐ Slight ☐ M		ere				

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

□ Other

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

sexual) ☐ Family member incarcerated ☐ Lack of support/help

 \Box Financial/money \Box Emotional loss \Box Health insurance

☐ Drugs ☐ Alcohol ☐ Violence/abuse (physical, emotional and/or

and /or SBIRT screening tools

☐ Witnessed violence/abuse

☐ Access to firearm(s)/weapon(s)

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

Thoughts/plans to harm ☐ Self ☐ Others ☐ Animals ☐ NA

Do you wear protective gear, including seat belts? ☐ Yes ☐ No ☐ Excessive television/video game/internet/cell phone use

☐ Has a firearm(s)/weapon(s)

☐ Threatened with violence/abuse

Screen Date	
-------------	--

*See Periodicity Schedule for Risk Factors

18, 19 and 20 Year Form, Page 2

Name			DOB	Age Sex: 🗆 M 🗆 F
General Health	Physical Exami	nation (N=Normal, .	Abn=Abnormal)	Plan of Care
☐ Growth plotted on growth chart	General Appearance	e □N □ Abn	·	Assessment
☐ BMI calculated and plotted on BMI chart	Skin	□ N □ Abn		☐ Well Child ☐ Other Diagnosis
·	Neurological	□ N □ Abn		
Nutrition/Physical Activity/Sleep	Reflexes	□ N □ Abn		Immunizations
Normal eating habits? ☐ Yes ☐ No	Head	□ N □ Abn		□ UTD □ Given, see immunization record □ Entered into WVSIIS
Fruits/vegetables/lean protein per day	Neck	□ N □ Abn		
□ Vitamins	Eyes	□ N □ Abn		Labs
□ Normal elimination	Ears	□ N □ Abn		☐ Hemoglobin/hematocrit (if high risk)
☐ Physical activity/exercise an hour most days	Nose	□ N □ Abn		☐ TB skin test (if high risk)
Type of physical activity/exercise	Oral Cavity/Throat	□ N □ Abn		☐ Fasting lipoprotein (once between 17 and 20 years and/or high
Normal sleeping patterns? ☐ Yes ☐ No	Lung	□ N □ Abn		risk)
Hours of sleep each night?	Heart	□ N □ Abn		☐ STI test (if sexually active and/or high risk)
	Pulses	□ N □ Abn		☐ HIV test (once between 15 and 18 years, if sexually active and/
Oral Health	Abdomen	□ N □ Abn		or high risk)
Date of last dental visit	Genitalia	□ N □ Abn		☐ Hepatitis C Virus Test (once between 18 and 79 years)
Current oral health problems	Back	□ N □ Abn		□ Other
	Hips	□ N □ Abn		
Vision Acuity Screen: (Subjective 18-20 years)	Extremities	□ N □ Abn		
RL	If female:			Referrals
Wears glasses? ☐ Yes ☐ No	LMP	🗆 Regular 🛭	□ Irregular	☐ Mental/behavioral health/trauma - Help4WV.com/1-844-435-7498
	Bleeding	□ Normal □ Heav	ry	☐ Substance abuse - Help4WV.com/1-844-435-7498
Hearing Screen (Objective once between 18 and 20 years)	Cramping	□ No □ Slight □ \$	Severe	☐ Dental ☐ Vision ☐ Hearing
20db@				□ Other
R ear: 500HZ 1000HZ 2000HZ 4000HZ	Possible Signs of	Abuse/Neglect 🗆 Ye	es □ No	
L ear: 500HZ 1000HZ 2000HZ 4000HZ				☐ Family Planning Program (FPP) 1-800-642-9704
				☐ Children with Special HealthCare Needs (CSHCN)
R ear: 6000HZ 8000HZ				1-800-642-9704
L ear: 6000HZ 8000HZ				☐ Transition to adult-oriented health care/medical home
Wears hearing aids? ☐ Yes ☐ No	Age Appropriat	e Health Educati	on/Anticipatory	
	Guidance (Consu	ılt Bright Futures, Foເ	ırth Edition. For further	Medical Necessity
*Anemia Risk (Hemoglobin/Hematocrit)	information: https://k	orightfutures.aap.org)		For treatment plans requiring authorization, please complete
□ Low risk □ High risk		of Health, Physical F		page 3. Contact a HealthCheck Regional Program Specialist for
*Tubaraulasia Diak	Promotion, Emotion	al Well-Being, Risk R	eduction, and Safety	assistance at 1-800-642-9704 or dhhr.wv.gov/healthcheck.
*Tuberculosis Risk □ Low risk □ High risk				
L LOW HOR LITTINGTHOR				Follow Up/Next Visit ☐ 19 years of age ☐ 20 years of age
*Dyslipidemia Risk				□ Other
☐ Low risk ☐ High risk Fasting lipoprotein required once between 17 and 20 years				
rasung iipoprotein required once between 17 and 20 years				☐ Screen has been reviewed and is complete
*STI Risk				
□ Low risk □ High risk				
*HIV Risk				
□ Low risk □ High risk				Please Print Name of Facility or Clinician
HIV test required once between 15 and 18 years				

Signature of Clinician/Title

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

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