

Screen Date _____

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

15, 16 and 17 Year Form

Name _____ DOB _____ Age _____ Sex: M F

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

Allergies NKDA _____

Current meds None _____

Foster Child Child with special health care needs IEP/section 504 in place _____

Accompanied by N/A Parent Grandparent Foster parent Foster organization _____ Other _____

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

Vision Acuity Screen: (Objective 15 years)

R _____ L _____

Wears glasses? Yes No

Hearing Screen (Objective, once between 15 and 17 years)

20db@

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

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

R ear: _____ 6000HZ _____ 8000HZ

L ear: _____ 6000HZ _____ 8000HZ

Wears hearing aids? Yes No

Developmental Surveillance

Concerns about behavior, 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 (FP) **1-800-642-9704**

Children with Special HealthCare Needs (CSHCN)

1-800-642-9704

Please Print Name of Facility or Clinician

Signature of Clinician/Title

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

Medical History

Initial Screen Periodic screen

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

Family health history reviewed _____

Concerns and/or questions _____

Social/Psychosocial History

What is your living situation? _____

Family relationships Good Okay Poor

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

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

What are your future plans? _____

What interests do you have outside of school and/or work? _____

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 _____

Concerns and/or questions _____

Traumatic Stress Reactions/PCL-C¹

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

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

Repeated, disturbing memories, thoughts, or images of a stressful experience from the **past**? Not at all A little bit(1)

Moderately(2) Quite a bit(3) Extremely(4)

Feeling very upset when something reminded you of a stressful experience from the **past**? Not at all A little bit(1)

Moderately(2) Quite a bit(3) Extremely(4)

Depression Screen/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)

Little interest or pleasure in doing things: Not at all Several days(1)

More than ½ the days(2) Nearly every day(3)

Feeling down, depressed, or hopeless: Not at all Several days(1)

More than ½ the days(2) Nearly every day(3)

Risk Indicators (✓ Check those that apply)

None identified *Tobacco use Cigarettes # per day _____

E-Cigarettes *Chew Passive Smoke Risk

*Alcohol use _____

*Drug use (prescription or otherwise) _____

***If positive see Periodicity Schedule for links to CRAFFT**

and /or SBIRT screening tools

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

Thoughts/plans to harm Self Others Animals NA

Continue on page 2

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



Name _____ DOB _____ Age _____ Sex: M F

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

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

Are you sexually active? Yes No

Method of contraception _____

Do you have children? Yes No _____

General Health

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

Nutrition/Physical Activity/Sleep

Normal eating habits? Yes No
 Fruits/Vegetables/Lean protein per day _____
 Vitamins _____
 Normal elimination _____
 Physical activity/exercise an hour most days
 Type of physical activity/exercise _____
 Normal sleeping patterns? Yes No
 Hours of sleep each night? _____

***See Periodicity Schedule for Risk Factors**

***Anemia Risk (Hemoglobin/Hematocrit)**

Low risk High risk

***Tuberculosis Risk**

Low risk High risk

***Dyslipidemia Risk**

Low risk High risk

Fasting lipoprotein required once between 17 and 20 years

***STI Risk**

Low risk High risk

***HIV Risk**

Low risk High risk

HIV test required once between 15 & 18 years

Physical Examination (N=Normal, Abn=Abnormal)

General Appearance N Abn _____
 Skin N Abn _____
 Neurological N Abn _____
 Reflexes N Abn _____
 Head N Abn _____
 Neck N Abn _____
 Eyes N Abn _____
 Ears N Abn _____

Nose N Abn _____
 Oral Cavity/Throat N Abn _____
 Lung N Abn _____
 Heart N Abn _____
 Pulses N Abn _____
 Abdomen N Abn _____
If female:
 LMP _____ Regular Irregular
 Bleeding Normal Heavy
 Cramping No Slight Severe
 Genitalia N Abn _____
 Back N Abn _____
 Hips N Abn _____
 Extremities N Abn _____

Possible Signs of Abuse Yes No

Concerns and/or questions _____

Anticipatory Guidance

*(Consult Bright Futures, Fourth Edition for further information
<https://brightfutures.aap.org>)*

Social Determinants of Health

- Interpersonal violence (fighting, bullying)
- Living situation and food security
- Family substance use (tobacco, E-cigarettes, alcohol, drugs)
- Connectedness with family and peers
- Connectedness with community
- School/work performance
- Coping with stress and decision making

Physical Health and Health Promotion

- Oral health
- Body image
- Healthy eating
- Physical activity and sleep

Emotional Well-being

- Mood regulation and mental health
- Sexuality

Risk Reduction

- Pregnancy and sexually transmitted infections
- Tobacco, e-cigarettes, alcohol, prescription drugs or street drugs
- Acoustic trauma

Safety

- Seat belt and helmet use
- Driving
- Sun protection
- Firearm safety

Other _____

Plan of Care

Assessment Well Child Other Diagnosis

Labs

- Hemoglobin/hematocrit (*if high risk*)
- TB skin test (*if high risk*)
- 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 & 18 years, if sexually active and/or high risk**)
- Other _____

Referrals

See page 1, school requirements

Prior Authorizations

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

Follow Up/Next Visit 16 years of age 17 years of age

Other _____

Screen has been reviewed and is complete

See page 1, school requirements for required signature