

Screen Date _____

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) HealthCheck Program Preventive Health Screen

Name _____ DOB _____ Age _____ Sex: M F Wt _____ Ht _____ BMI _____ BP _____ Pulse _____ Temp _____

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent Foster organization Other _____

Health conditions that may require care at school _____

Immunizations: Attach current immunization record
 UTD Given, see vaccine record
 Vision Acuity Screen (Obj @ 12 yrs) R _____ L _____
Wears glasses Yes No
 Hearing Screen as indicated by risk screen: 20 db@
R ear: _____ 500HZ R ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
L ear: _____ 500HZ L ear: _____ 1000HZ _____ 2000HZ _____ 4000HZ
Wears hearing aids Yes No

Oral Health Screen
Date of last dental visit _____
 Current oral health problems:
 Developmental Surveillance
Referrals: Behavioral/Mental Health Dentist Vision
 Hearing FP CSHCN 1-800-642-9704

Provider signature required for validation
 Risk indicators reviewed/screen complete
Please Print Name of Facility or Clinic _____
Signature of Clinician/Title _____
The information above this line is intended to be released to meet school entry requirements.

School Entry Requirements

History: No change
Concerns and questions:
Follow up on previous concerns:
Recent injuries, illnesses, visits to other providers or counselors and/or hospitalizations:

Psychosocial/Behavior Screen: Check those that apply
Fun activities:
Friend(s): Yes No
 Thoughts/plans to harm Self Others Animals NA
 Experienced an emotional loss

Changes since last visit:
Nutrition:
 Normal eating habits _____
 Vitamins: _____
 Normal elimination Normal sleep patterns

Social Emotional Health/Interpersonal Trauma
Social/Family: Check those that apply
Family situation: No change
Parent(s)/Caretaker(s) working outside home? Yes No
Child care? Yes No NA
Have you lived anywhere but with your parents/caregivers?
 Yes No _____
Sibling(s) in the home? Yes No _____
Do you get along with other family members? Yes No
If you could, how would you change your life?
home? _____
family? _____

Risk indicators: Check those that apply
 None identified Poor self image
 Lack of physical activity Weight or height concerns
 Tobacco use: Cigarettes/# per day _____
 E-Cigs Chew Passive Smoking Risk
 *Alcohol use _____ *Other drugs _____
*If positive see Periodicity Schedule
 Access to weapon(s) Has a weapon(s)
 Witnessed violence Threatened with violence
Has anyone ever hit, choked, kicked or hurt you? Yes No
Have you ever been in jail? Yes No
Do you wear protective gear, including seat belts? Yes No
 Excessive television/video game/internet/cell phone use
School/Grade _____
 Attends school regularly
How are you doing in school?
 Special classes _____
 Trouble at school _____
 Participates in extracurricular activities _____

See Periodicity Schedule for risk indicators
Hemoglobin/Hematocrit Risk: Low risk High risk
Dyslipidemia Risk: Low risk High risk
Tuberculosis Risk: Low risk High risk
Physical Examination: = Normal limits
 General Appearance Skin Neurological
 Reflexes Head Neck
 Eyes Ears Nose
 Oral Cavity/Throat Lungs Heart
 Pulses Abdomen Genitalia
 Back Extremities
Possible Signs of Abuse Yes No

Traumatic Stress Reactions¹: Check one for each question
Feelings over the past 2 weeks:
Repeated, disturbing memories, thoughts, or images of a stressful experience from the past? Not at all
 A little bit (1) Moderately (2) Quite a bit (3)
 Extremely (4)
Feeling very upset when something reminded you of a stressful experience from the past? Not at all
 A little bit (1) Moderately (2) Quite a bit (3)
 Extremely (4)

Relationship/Sex education: Check those that apply
Has anyone ever touched you in a sexual way or made you touch them when you did not want to? Yes No
Are you in a relationship? _____ Male _____ Female
Do you feel safe in your relationship? Yes No
Pressure to have sex Yes No
Sexually Active? Yes No
Method of contraception _____ NA
Do you have any children? Yes No _____
*STI/HIV screening _____ NA
*If positive see Periodicity Schedule

Health Education/Anticipatory Guidance:
 Discussed Handout(s) given
Healthy and safe habits: nutrition, sleep, oral/dental care, risk behaviors, sexuality, injury and violence prevention, mental health, substance use/abuse, social competence, responsibility, school achievement, family relationships, community interaction
Assessment: Well Child Other Diagnosis
Labs:
Referrals*: (see above) Other
* See Provider Manual for automatic referrals

Depression Screen: Check one for each question
If Positive see Periodicity Schedule
Feelings over the past 2 weeks:
Little interest or pleasure in doing things: Not at all
 Several days More than 1/2 the days Nearly every day
Feeling down, depressed, or hopeless: Not at all
 Several days More than 1/2 the days Nearly every day

Physical Health
Current Health Indicators: Check those that apply
 No change LMP _____ NA

Prior Authorizations:
For treatment plans requiring authorization, please complete page 2 on the reverse. Contact a HealthCheck Regional Program Specialist for assistance at 1-800-642-9704 or www.dhhr.wv.gov/healthcheck
Follow Up/Next Visit: 12 years of age 13 years of age
 14 years of age Other

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., Bystritsky, 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.
An individual is considered to have screened positive if the sum of the numbered responses is 4 or greater. For assistance phone 844-HELP4WV (844-435-7498).