Pediatric Health Risk Assessment Form

PASSPORT HEALTH PLAN

Now that your child is a member of Passport Health Plan, we ask that you please fill out this form. It will help us see how we can best serve you with our benefits and special programs. Your answers on this form are kept private. The answers will not affect your benefits in any way. If you need help filling out this form, please call 1-877-903-0082. TDD/TTY users may call 1-800-691-5566.

Date _____

Child's Name (first) _____ **(middle initial)** _____ **(last)** _____

Address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Daytime Phone _____ **Child's Date of birth** _____

Last four digits of your child's Social Security #: _____

Child's Passport Health Plan ID number: _____

What is the name of your child's primary care provider (PCP)? _____

What is your child's PCP's phone number? _____

Do you need help choosing a PCP for your child or making an appointment with your child's PCP? ❑ Yes ❑ No

When was your child's last:
Physical exam? _____ **Dental Exam?** _____ **Eye Exam:** _____

Is your child up to date on all immunizations? ❑ Yes ❑ No ❑ Not sure ❑ Other: (please explain) _____

What is your child's current height? _____ **What is your child's current weight?** _____

What is your child's preferred language?

❑ English ❑ Somali ❑ Spanish ❑ Arabic ❑ Vietnamese ❑ Bosnian
❑ Russian ❑ Swahili ❑ French ❑ Mandarin ❑ Sign ❑ Other _____

What is your child's gender? ❑ Male ❑ Female

What is your child's race? (optional)

❑ American Indian/ Alaskan Native ❑ Black or African American ❑ White
❑ Native Hawaiian/ Pacific Islander ❑ Asian ❑ Other_____

What is your child's ethnicity? (optional)

❑ Hispanic ❑ Non-Hispanic ❑ Other_____

Who is answering the questions on this survey?

❑ Mother ❑ Father ❑ Grandparent ❑ Foster parent ❑ Child ❑ Other family member (please explain)_____
❑ Other (please explain)_____

ALL AGES CONTINUE

Section One: FOR ALL AGES
Please answer the following questions in response to your child. Only select one response per question.

1. Has your child's doctor told you that your child had any of the following conditions? (Check ALL that apply)

A. Lung problems, such as:

❑ Asthma ❑ Allergies ❑ Bronchiolitis ❑ Cystic Fibrosis ❑ Ventilator dependent

❑ Other:_____

B. Heart problems, such as:

❑ High Blood Pressure ❑ Birth Defect ❑ Heart Failure

❑ Other:_____

C. Neurological problems, such as:

❑ CVA/Stroke ❑ Para/Quadriplegia ❑ Seizures

❑ Other:_____

D. GI Problems, such as:

❑ Reflux ❑ Ostomy ❑ Failure to thrive

❑ Other:_____

E. Behavioral/Mental Health Issues, such as:

❑ ADHD/ADD ❑ Anorexia, Bulimia, or other eating disorder ❑ Anxiety ❑ Bipolar ❑ Depression

❑ Substance/Drug Abuse ❑ Substance Overdose ❑ Stress/Feeling Overwhelmed

❑ Other:_____

F. Blood Disorders

❑ Anemia ❑ Sickle Cell ❑ Hemophilia

❑ Other:_____

G. ❑ Autism

H. ❑ Cancer (type)_____

I. ❑ Cerebral Palsy (CP)

J. ❑ Diabetes

K. ❑ Growth/Development Delays

L. ❑ Hearing Problems

M. ❑ HIV/AIDS

N. ❑ Kidney Problems

O. ❑ Liver Conditions

P. ❑ Obesity/Overweight

Q. ❑ Premature Birth

R. ❑ Vision Problems

S. ❑ Migraine / Headaches

T. ❑ Other (please explain)_____

ALL AGES CONTINUE

2. Do you understand all of your child's medical issues?

❑ Yes

❑ No If no, which one do you want to know more about? (please list)_____

❑ Not applicable

3. Does your child understand their medical issues?

❑ Yes

❑ No If no, which one does your child want to know more about? (please list)_____

❑ Not applicable

4. If you or your child wants to know more about your child's medical issues - what would you and your child like to know? (Check all that apply)

❑ Diagnosis ❑ Medications ❑ Diet/nutrition ❑ Signs and symptoms ❑ How to know when your child is getting worse

❑ Complications ❑ Treatment options ❑ Possible equipment to make the condition easier to manage

❑ Other (please explain) _____

5. Has your child ever had surgery?

❑ Yes If yes, what surgeries has your child had (please list all)_____

❑ No

6. Has your child been in the emergency room (ER) in the last 6 months?

❑ Yes ❑ No

7. Has your child been in the hospital in the last 6 months?

❑ Yes ❑ No

8. Does your child take any medicines that are prescribed by a doctor ?

❑ Yes If yes, what medicines does your child take (please list all)_____

❑ No

9. Does your child take over-the-counter medicines?

❑ Yes If yes, please list_____

❑ No

10. Do you or your child need help understanding any of the medicines?

❑ Yes If yes, which medicine(s)_____

❑ No

11. Is your child allergic to any medicines?

❑ Yes If yes, please list_____

❑ No

12. Do you or your child use any cultural or home remedies?

❑ Yes If yes, please explain_____

❑ No

ALL AGES CONTINUE

13. Does your child receive any of the following services at home? (check all that apply)

❑ Speech therapy ❑ Physical therapy ❑ Occupational therapy ❑ Nursing services ❑ Home health aide

❑ Respiratory therapist ❑ Other (please explain)_____

14. Do you have any problems with the services being provided in the home?

❑ Yes ❑ No

15. Does your child's care require medical equipment in the home?

❑ Yes If yes, what medical equipment_____

❑ No

16. Do you have any problems with the medical equipment service being provided in the home?

❑ Yes If yes, what medical equipment_____

❑ No

❑ Not applicable

17. Does your child have problems with mobility (crawling and walking) in the home?

❑ Yes ❑ No

18. What type of transportation do you and your child use to get to medical appointments? (Check all that apply)

❑ Car ❑ Bus ❑ Cab ❑ Family/Friends to drive you and your child ❑ Ambulance ❑ Walk

19. Is your child on a special diet?

❑ Yes If yes, what type of diet_____

❑ No

20. Does your child have healthy eating habits. (Check all that apply)

❑ Drinks milk daily ❑ Eats fruits daily ❑ Eats vegetables daily ❑ Avoids sugary drinks ❑ Eats 3 meals per day

❑ Other (please list) _____

21. Does your child see a specialist in addition to their PCP?

❑ Yes If yes, what type of specialist_____

❑ No

22. Does your child see a behavioral/mental health provider?

❑ Yes ❑ No

23. Has your child ever been admitted to a mental health hospital?

❑ Yes ❑ No

24. Are you concerned that your child may need to see a behavioral/mental health provider?

❑ Yes ❑ No

ALL AGES CONTINUE

25. Does your child attend school?

❑ Yes ❑ No

26. Does your child's physical or mental health keep them from attending school?

❑ Yes ❑ No

27. Do you feel that you have barriers that keep you from getting your child the health care they need?

❑ Yes ❑ No

If yes, which barriers do you feel keep you from getting health care? (Check all that apply)

a. ❑ Office hours
b. ❑ Lack of knowledge about Disease/condition
c. ❑ Do not believe participation will improve health
d. ❑ Issues with medication benefits
e. ❑ Transportation
f. ❑ Lack of support from family
g. ❑ Lack of medical equipment
h. ❑ Language barrier
i. ❑ Lifestyle choices (diet, exercise, smoking, etc.)
j. ❑ Don't know what I need
k. ❑ No available/convenient providers
l. ❑ PCP doesn't help you understand
m. ❑ Your health
n. ❑ Vision/hearing impairment
o. ❑ Other _____

28. In general, would you say your child's health is: (Please circle one)

1 - Excellent 2 - Very Good 3 - Good 4 - Fair 5 - Poor

29. Do you need help getting food, clothing, housing, or utilities?

❑ Yes ❑ No ❑ Not Sure

30. Does anyone in your home smoke?

❑ Yes ❑ No

ALL AGES CONTINUE

Section A — STOP Complete this additional section for a newborn or infant up to the age of 1 year ONLY	
	These questions are about your child's developmental milestones. (Check yes or no)
❑ Yes ❑ No	Do you think your baby sees you?
❑ Yes ❑ No	Does your baby react to your voice?
❑ Yes ❑ No	Does your baby have a sleeping routine?
❑ Yes ❑ No	Does your baby have an eating routine?
❑ Yes ❑ No	Does your baby smile at you?
❑ Yes ❑ No	Does your baby babble at you?
❑ Yes ❑ No	Does your child eat baby foods such as cereal, fruits, and/or vegetables?
	These questions are about your child's safety. (Check yes or no)
❑ Yes ❑ No	Does your baby have a place to sleep such as crib or bassinet?
❑ Yes ❑ No	Does your baby sleep on their back?
❑ Yes ❑ No	Is your child's bedding tight on the mattress?
❑ Yes ❑ No	Do your remove your child's bedding include pillows or fluffy comforters or bumper pads when you put your child to bed?
❑ Yes ❑ No	Do you remove pacifier clips before you put your child down to sleep?
❑ Yes ❑ No	Is your child always placed in a rear facing car seat in the back seat when riding in a car?
❑ Yes ❑ No	Do you have a working smoke detector in the home?
	Please answer each of the following questions with YES or NO regarding your child's health.
❑ Yes ❑ No	Do you have reliable child care?
❑ Yes ❑ No	Do you and other caregivers wash their hands frequently to prevent germs?
❑ Yes ❑ No	Does anyone in your home smoke?
❑ Yes ❑ No	Do you know first aid?
❑ Yes ❑ No	Do you have a list of emergency numbers (such as Poison Control, your child's doctor)?

Section B — STOP **Complete this additional section for a child ages 1- 4 years ONLY**

These questions are about your child's developmental milestones.
Can your child: (check all that apply)

❑ Yes ❑ No	Crawl
❑ Yes ❑ No	Pull up on furniture
❑ Yes ❑ No	Walk with support
❑ Yes ❑ No	Walk without support
❑ Yes ❑ No	Run
❑ Yes ❑ No	Throw a ball
❑ Yes ❑ No	Push a toy
❑ Yes ❑ No	Climb stairs
❑ Yes ❑ No	Grasp a pencil/crayon
❑ Yes ❑ No	Speak in 2-3 word sentences
❑ Yes ❑ No	Speak in full sentences
❑ Yes ❑ No	Do you feel your child is doing things that other children the same age are able to do?

These questions are about your child's safety. (Check yes or no)

❑ Yes ❑ No	1. Is your child always placed in safety restraints in the car (i.e. car seats, or booster seats)?
❑ Yes ❑ No	2. Does your child wear safety gear while riding a tricycle/bicycle?
❑ Yes ❑ No	3. Does your child know fire safety and water safety ?
❑ Yes ❑ No	4. Does your child know and can state his/her telephone number (or a parent's) and address?
❑ Yes ❑ No	5. Does your child know about stranger safety?
❑ Yes ❑ No	6. Are cleaning, laundry, and other chemicals out of reach?
❑ Yes ❑ No	7. Do you have important safety numbers posted in your home (i.e. Poison Control, the child's PCP phone number)?
❑ Yes ❑ No	8. Does anyone in your home own a gun?
❑ Yes ❑ No	9. If yes, is the gun kept unloaded and locked?
❑ Yes ❑ No	10. Do you have stairs?
❑ Yes ❑ No	11. If yes, do you have gates at the top and bottom of stairs?
❑ Yes ❑ No	12. Do you have a working smoke detector in the home?

Please answer each of the following questions with YES or NO regarding your child's health.

❑ Yes ❑ No	1. Does your child wash his/her hands to prevent the spread of germs?
❑ Yes ❑ No	2. Does your child brush his/her teeth at least twice per day?
❑ Yes ❑ No	3. Does your child see a dentist every 6 months?
❑ Yes ❑ No	4. Does your child use sunscreen when exposed to the sun?
❑ Yes ❑ No	5. Is your child potty trained during the day?
❑ Yes ❑ No	6. Is your child potty trained at night?
❑ Yes ❑ No	7. Does your child use pull-ups or wet the bed during the night?
❑ Yes ❑ No	8. Have you ever been told by your doctor that your child needs to lose weight?

Section C— STOP Complete this additional section for a child ages 5-10 Years ONLY	
	These questions are about your child's developmental milestones.
❑ Yes ❑ No	Does your child dress with minimal assistance?
❑ Yes ❑ No	Does your child balance on one foot, hop, or skip?
❑ Yes ❑ No	Can your child tell a simple story?
❑ Yes ❑ No	Does your child have daily chores?
	Please answer each of the following questions with YES or NO regarding your child's safety.
❑ Yes ❑ No	Do you or your child have concerns about bullying?
❑ Yes ❑ No	Does anyone in your home own a gun?
❑ Yes ❑ No	If yes, is it kept unloaded and locked?
❑ Yes ❑ No	Do you have working smoke detectors in your home?
❑ Yes ❑ No	Does your child know fire safety?
❑ Yes ❑ No	Do you have a fire escape plan?
❑ Yes ❑ No	Does your child know what to do in case of an emergency?
❑ Yes ❑ No	Does your child always wear safety helmet when riding a bicycle?
❑ Yes ❑ No	Does your child know water safety?
❑ Yes ❑ No	Does your child know how to safely cross the street?
❑ Yes ❑ No	Does your child know about stranger safety?
❑ Yes ❑ No	Does your child know that older children and other adults should not touch them in their private areas and that it is okay to tell you if anyone tries to touch them?
	Please answer each of the following questions with YES or NO regarding your child's health.
❑ Yes ❑ No	Do you have concerns about your child's ability to do school work?
❑ Yes ❑ No	Does your child like school?
❑ Yes ❑ No	Does your child miss school for health reasons?
❑ Yes ❑ No	Does your child wash his/her hands to prevent the spread of germs?
❑ Yes ❑ No	Does your child see the dentist every 6 months?
❑ Yes ❑ No	Does your child get 60 minutes of exercise every day?
❑ Yes ❑ No	Does your child eat fruits and vegetables every day?
❑ Yes ❑ No	Does your child brush his/her teeth at least twice per day?
❑ Yes ❑ No	Have you ever been told by your doctor that your child needs to lose weight?

Section D — STOP **Complete this additional section for a child ages 11-20 years ONLY**

These questions are for the parent to complete:

Do you have concerns about your child's:

❑ Yes ❑ No	Health?
❑ Yes ❑ No	Nutrition?
❑ Yes ❑ No	Weight?
❑ Yes ❑ No	Activity?
❑ Yes ❑ No	Does your child get along with the family?
❑ Yes ❑ No	Do you do things as a family?
❑ Yes ❑ No	Does your child have after school activities?
❑ Yes ❑ No	Is your child doing okay in school (grades are passing) ?
❑ Yes ❑ No	Does your child skip school?
❑ Yes ❑ No	Have you noticed puberty changes in your child such as deeper voice, body hair, menstrual cycle?
❑ Yes ❑ No	Do you think your child solves problems well?
❑ Yes ❑ No	Has your child experimented with smoking?
❑ Yes ❑ No	Has your child experimented with drugs of any kind?
❑ Yes ❑ No	Has your child experimented with huffing?
❑ Yes ❑ No	Has your child asked questions about sex?
❑ Yes ❑ No	Do you think your child might be sexually active?
❑ Yes ❑ No	Do you think your child might be pregnant?

	These are questions for the pre-teen or teen to complete:
❑ Yes ❑ No	Do you like the way you look?
❑ Yes ❑ No	Do you think you are overweight?
❑ Yes ❑ No	Do you think you need to gain weight?
❑ Yes ❑ No	Are you currently doing anything to change your weight?
❑ Yes ❑ No	Do you get exercise each day?
❑ Yes ❑ No	Would you say that you get along well with your family?
❑ Yes ❑ No	Do you have things you like to do after school?
	If yes, what do you like to do? _____
❑ Yes ❑ No	Do you like school?
❑ Yes ❑ No	Do you have friends at school?
❑ Yes ❑ No	Do you skip school?
	When you have a problem with school or a friend, Do you get: (check all that apply)
❑ Yes ❑ No	Angry
❑ Yes ❑ No	Anxious
❑ Yes ❑ No	Nervous
❑ Yes ❑ No	Sad
❑ Yes ❑ No	Do you or have you smoked?
❑ Yes ❑ No	Do you or have you drank alcohol?
❑ Yes ❑ No	Do you or have you huffed?
❑ Yes ❑ No	Do you or have you used drugs of any kind?
❑ Yes ❑ No	Have you ever felt pressure to do things that other teens want you to do?
❑ Yes ❑ No	Have you had sex?
❑ Yes ❑ No	Do you feel pressured to have sex?
❑ Yes ❑ No	Do you think you might be pregnant?
❑ Yes ❑ No	Do you have someone you can trust to talk to?
❑ Yes ❑ No	Have you ever thought about harming yourself?
❑ Yes ❑ No	Has anyone ever tried to hurt you?
❑ Yes ❑ No	Are you or have you been in a relationship with someone that threatens you?
❑ Yes ❑ No	Do you always wear a seat belt when in a car?
	What do you want to do after you graduate from school? _____

Thank you for taking time and completing the Pediatric Health Risk Assessment, your health is important to us!

We will evaluate the information provided to us in our efforts to help you improve your child's quality of life!

Please mail this questionnaire back in the postage-paid envelope provided, or to the following address:

Passport Health Plan
Attn: Pediatric Health Risk Assessment
5100 Commerce Crossings Drive
Louisville, KY 40229