



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

11, 12, 13 and 14 Year Form

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

Allergies: NKDA _____ Current Meds: None _____

Accompanied by: Parent Grandparent Foster parent/organization Other _____

History: No change
 Concerns and questions:

Follow up on previous concerns:

Recent injuries, illnesses or visits to other providers:

Social/Family History: Check those that apply
 No change
 Family situation change

Parents working outside home? Mother Father
 Child care? No Yes _____
 Other changes since last visit:

Current Health Indicators: Check those that apply
 No change LMP _____ N/A
 Changes since last visit:

GROWTH PLOTTED ON GROWTH CHART
 BMI CALCULATED AND PLOTTED ON BMI CHART
 Normal elimination Normal sleep patterns
 Comments:

Nutrition: Normal eating habits
 Vitamins: _____
 Comments:

Passive Smoking Risk: Yes No

Check those that apply
 Dyslipidemia Risk: Low risk High risk
 See Periodicity Schedule for risk indicators

Tuberculosis Risk: Low risk High risk
 See Periodicity Schedule for risk indicators

Behavior/Mental Health Screen: Check those that apply
 Appropriate behavior: Yes No
 Fun activities: _____

Friend(s): Yes No
 Concern(s): Yes No
 Feelings: Content
 Sad Less than a week More than a week
 Angry Less than a week More than a week
 Down/depressed Less than a week More than a week
 Thoughts/plans to harm Self Others Animals
 Trouble at school Trouble with the law

Behavioral concerns/comments: Yes No

Risk indicators: Check those that apply None identified
 Poor self image Lack of physical activity
 Weight or height concerns _____
 Tobacco use: Cigarettes/# per day _____ Chew
 Alcohol use _____ Other drug _____
 Peer pressure to do things you don't want to do:

_____ Pressure to have sex Inappropriate touching
 Does not wear protective gear, including seat belts
 Access to firearms Has a firearm
 Witnessed violence Threatened with violence
 Excessive television/video game use (>2 hrs. per day)
 School: Grade _____

Attends school regularly
 Special classes _____
 Likes most about school: _____

Likes least about school: _____

Proud of: _____

Participates in activities _____
 Plans after high school _____

Family/Sexuality:
 Gets along with other family members
 If you could, how would you change your life?

home? _____
 family? _____

Sex education/questions
 Sexually active? Yes No STIs _____ N/A
 Method of contraception _____ N/A

Vision Acuity Screen (Obj @ 12 yrs) R _____ L _____

Hearing Screen as indicated by risk screen: 20db@
 R ear: _____ 500HZ _____ 1000HZ _____ 2000HZ _____ 4000HZ
 L ear: _____ 500HZ _____ 1000HZ _____ 2000HZ _____ 4000HZ

Oral Health Screen
 Date of last dental visit _____
 Current oral health problems:

Physical Examination: = Normal limits

<input type="checkbox"/> General Appearance	<input type="checkbox"/> Skin
<input type="checkbox"/> Neurological	<input type="checkbox"/> Reflexes
<input type="checkbox"/> Head	<input type="checkbox"/> Neck
<input type="checkbox"/> Eyes	<input type="checkbox"/> Ears
<input type="checkbox"/> Nose	<input type="checkbox"/> Oral Cavity/Throat
<input type="checkbox"/> Lungs <input type="checkbox"/> Heart	<input type="checkbox"/> Pulses
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Genitalia
<input type="checkbox"/> Back	<input type="checkbox"/> Extremities

Abnormal Findings and Comments:

Possible Signs of Abuse Yes No

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, family relationships and community interaction, school achievement, health care transition from adolescence to adulthood in the medical home (beginning at 14 years)
 Other:

Assessment: Well Child Other diagnosis
 Risk indicators reviewed/screen complete

Plan/Referrals:

For treatment plans requiring authorization, please complete the Medical Necessity Form on the reverse.

Immunizations: UTD Given, see vaccine record
 Labs:

Referrals*: Behavioral/Mental health Dentist Vision
 Hearing CSHCN 1-800-642-9704
 *See Provider Manual for automatic referrals
 Other referral(s)

Follow Up/Next Visit: 12 years of age 13 years of age
 14 years of age 15 years of age Other

 Please print Name of Facility or Clinician

 Signature of Clinician/Title

