Screen Date_____

West Virginia Department of Health and Human Resources
Early and Periodic 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 (*optional*)_____

Allergies ☐ NKDA _____

Current meds ☐ None_____

☐ Child with special health care needs_____ ☐ IEP/section 504 in place_____

Accompanied by ☐ N/A ☐ Parent ☐ Grandparent ☐ Other _____

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_____

_____

Are you in school? ☐ No ☐ High school ☐ College/vocational

Working? ☐ Yes ☐ No _____

What are your future plans?_____

_____

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

_____

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

_____

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/money ☐ Emotional loss ☐ Health Insurance

☐ Other_____

_____

_____

_____

Concerns and/or questions_____

_____

_____

_____

Traumatic Stress Reactions/PCL-C[1]

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

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?_____

Oral Health

Date of last dental visit_____

Current oral health problems _____

Vision Acuity Screen: *(Subjective 18-20 years)*

R _____ L _____

Wears glasses? ☐ Yes ☐ No

Hearing Screen (*Objective once between 18 and 20 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

[1]Lang, 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 PTSDT 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

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
- ☐ Living situation and food security
- ☐ Family substance use (tobacco, 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
- ☐ Transition to adult care

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 and substance use
- ☐ Sun protection
- ☐ Firearm safety

☐ Other
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Plan of Care

Assessment ☐ Well Child ☐ Other Diagnosis

Immunizations
☐ **UTD** ☐ Given, see immunization record ☐ Entered into WVSIIS

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
☐ 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**
☐ Transition to adult-oriented health care/medical home

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 ☐ 19 years of age ☐ 20 years of age
☐ Other_____

☐ Screen has been reviewed and is complete

_

_____
Please Print Name of Facility or Clinician

_____
Signature of Clinician/Title