of Tennessee

Reference #:

TN Division of Health Care Finance & Administration | CoverKids

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Parent Survey for Child Health Needs

- ***Please answer as many questions as you can.***

Leave blank the question(s) you cannot or choose not to answer.

Demographic Information

Child's Name: _____

Child's Address: _____

_____

Child's phone number:_____

Child's Date of Birth: ☐☐ ☐☐ ☐☐☐☐ MM DD YYYY

What is your child's gender? ○ **Male** ○ **Female**

Why are we doing this?

We want to help your child get high quality care that meets his/her needs. To do this, we need some information from you.

The information you provide us will be kept private. The information may be shared with members of your child's care team (primary care provider, specialists and case manager, if needed).

Your answers will be used to help us give your child the best information and service possible. Please complete and return this survey.

Notice: Completion of this form is considered an approval to utilize the information, as needed, to best coordinate your child's care.

For members under the age of 18, please tell us who is completing this survey?

○ Health representative ○ Parent

We use race, language and ethnic background to improve the quality of treatment and care that your child needs. We also use it to develop programs specific for your child.

1. Which of these best describes your child's race?
   - ○ American Indian/Alaskan Native
   - ○ Asian
   - ○ Black/African American
   - ○ Native Hawaiian/Other Pacific Islander
   - ○ White
   - ○ Declined

2. Do you consider your child Hispanic/Latino?
   - ○ Yes
   - ○ No
   - ○ Declined
   - ○ Unavailable/Unknown

3. What language does your child speak?_____

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Child Health History

4. Compared to others your child's age, how would you describe your child's overall health?
   - ○ Excellent ○ Very good ○ Good ○ Fair ○ Poor

5. Does your child have any of the special needs or disabilities listed below?
   - ☐ Hearing Impairment ☐ Deaf ☐ Vision Impairment
   - ☐ Blind ☐ Learning Disability ○ None

6. Does your child have a doctor?
   - ○ Yes ○ No

7. Has your child had a medical checkup in the last 12 months?
   - ○ Yes ○ No ○ I don't know

8. How tall is your child? ____feet ____inches ____ unknown

   How much does your child weigh? _____pounds ____ unknown

9. For children who are old enough, how often does your child get 60 minutes of physical activity a day (such as playing sports, Wii Fit, walking fast or running)?
   - ○ Less than 1 time per week ○ 1 to 2 times per week ○ 3 to 4 times per week
   - ○ 5 or more times per week ○ I don't know ○ Does not apply

10. Please answer each question below that describes your child.

    Does your child need or use **medicine prescribed by a doctor** (other than vitamins)?
    - ○ Yes ○ No ○ I don't know

    Does your child need or use more **medical care and/or mental health services** than other children his/her age?
    - ○ Yes ○ No ○ I don't know

    Does your child need or use **medical equipment** (such as, wheelchair, leg braces, nebulizer)?
    - ○ Yes ○ No ○ I don't know

    Is your child able to do the same things most children his/her age can do?
    - ○ Yes ○ No ○ I don't know

    Does your child need or get **special therapy**, like physical, occupational or speech therapy?
    - ○ Yes ○ No ○ I don't know

    Does your child need or get **treatment or counseling** for an emotional, developmental or behavioral problem?
    - ○ Yes ○ No ○ I don't know

11. Has your child had the flu shot or flu mist this year?
    - ○ Yes ○ No

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Child Health History (continued)

12. Has a doctor or other health care professional ever said your child has any of the following conditions?

Fill in all that apply.

- ☐ Anxiety
- ☐ Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ Behavior or conduct problems
- ☐ Brain Injury
- ☐ Heart conditions
- ☐ Slow or Delayed Development
- ☐ Low birth weight and or other birth problems
- ☐ Sleep problems
- ☐ Asthma
- ☐ Autism or Autism Spectrum Disorders
- ☐ Bipolar Disorder
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes or sugar
- ☐ Schizophrenia
- ☐ Sickle Cell Disease

13. For female children who are old enough, has your child started her menstrual cycle or period?

○ Does not apply ○ Yes ○ No *If no, go to question 14.*

Is your child pregnant?

○ Yes ○ No ○ I don't know

If yes, how long has she been pregnant?

○ 1 to 3 months ○ 4 to 6 months ○ 7 to 9 months ○ I don't know

If yes, is she currently getting care from a doctor or other health care professional for her pregnancy?

○ Yes ○ No ○ I don't know

Who is your child's doctor? _____

City and/or County? _____

14. In the past 12 months, how many times has your child:

Gone to the Emergency Room?

○ None ○ 1 to 2 ○ 3 to 5 ○ 6 or more ○ I don't know

Stayed overnight in a hospital?

○ None ○ 1 to 2 ○ 3 to 5 ○ 6 or more ○ I don't know

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Child Health History (continued)

15. For children ages 10 and above only, please fill in all that apply below.

During the past 12 months, did your child:

- ○ Smoke or use tobacco products
- ○ Drink alcohol (more than a few sips)
- ○ Smoke marijuana
- ○ Use anything else to get high ("Anything else" includes illegal drugs, over-the-counter and prescription drugs, and/or things that you sniff or huff)
- ○ Does not apply

16. Does your child need help in any of the following areas?

- ☐ Eating healthy
- ☐ Exercising or increasing physical activity
- ☐ Getting to or maintaining a healthy weight
- ☐ Managing stress
- ☐ Stop using drugs or alcohol
- ☐ Stop smoking or chewing tobacco
- ☐ No.

Thank you for allowing us to learn more about your child. We will use this information to help your child live healthier.

Do you need help in these languages: العربية (Arabic); Bosanski (Bosnian); کوردی – بادینانی (Kurdish-Badinani); کوردی – سۆرانی (Kurdish- Sorani); Soomaali (Somali); Español (Spanish); Người Việt (Vietnamese)

CoverKids language and member services are free at 1-888-325-8386, Monday-Friday, 8 a.m. to 6 p.m. ET. For TDD/ TTY help call 1-866-591-2908. Federal and State laws protect your rights. They do not allow anyone to be treated in a different way because of: race, language, sex, age, color, birthplace, or disability. Need help? Call the Office of Non-Discrimination Compliance for free at 1-855-286-9085. For TTY dial 711 and ask for 855-286-9085

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