Reference #:

TN Division of TennCare | CoverKids

Parent Survey for Child Health Needs

- Please fill in your responses like this using ONLY A BLUE OR BLACK PEN.
- Do NOT use GREEN INK.
- 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 Date of Birth _____ MM DD YYYY

Child's Gender ○ Male ○ Female

Child's Phone Number _____

Why are we doing this?

We want to provide you with high quality care that meets your 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 care team (primary care provider, specialists and case manager, if needed).

Your answers will be used to help us give you the best information and service possible. 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. Please complete and return this survey in the postage-paid envelope that has been provided.

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

○ Health representative ○ Parent

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

1. Which of these best describes your child's race?

○ American Indian/Alaskan Native ○ Asian ○ Black/African American
○ Native Hawaiian/Other Pacific Islander ○ White
○ I don't know ○ Declined

2. Do you consider your child Hispanic/Latino?

○ Yes ○ No ○ I don't know ○ Declined

3. What language does your child speak? _____

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4. Compared to others your child's age, how would you describe your child's overall health?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor
- ○ I don't know
- ○ Declined

5. Does your child have any of the special needs or disabilities listed below?

- ○ Hearing Impairment
- ○ Deaf
- ○ Vision Impairment
- ○ Blind
- ○ Learning Disability
- ○ None
- ○ I don't know
- ○ Declined

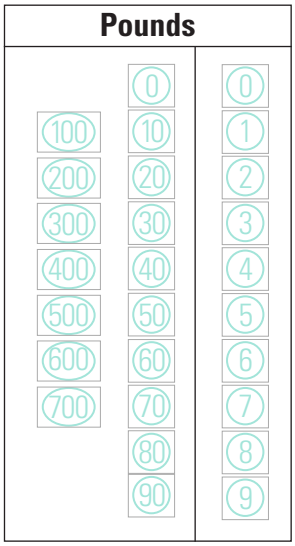
6. Does your child have a doctor?

- ○ Yes
- ○ No
- ○ I don't know
- ○ Declined

7. Has your child had a medical checkup in the last 12 months?

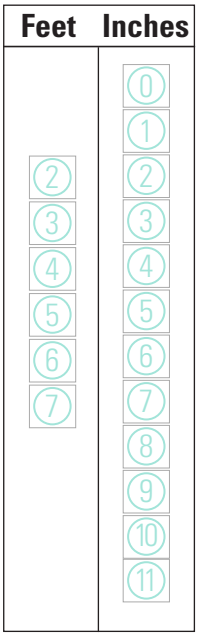
- ○ Yes
- ○ No
- ○ I don't know
- ○ Declined

8. How much does your child weigh?



- ○ I don't know
- ○ Declined

9. How tall is your child?



- ○ I don't know
- ○ Declined

10. 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
- ○ Declined

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11. How many servings of fruit does your child consume in a typical day?

- ○ 6 servings or more
- ○ 4-5 servings
- ○ 3 servings
- ○ 2 servings
- ○ 1 serving
- ○ Less than 1 serving
- ○ None
- ○ I don't know
- ○ Declined

12. How many servings of vegetables does your child consume in a typical day?

- ○ 7 servings or more
- ○ 5-6 servings
- ○ 4 servings
- ○ 3 servings
- ○ 2 servings
- ○ 1 serving
- ○ Less than 1 serving
- ○ None
- ○ I don't know
- ○ Declined

13. 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 ○ Declined

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 ○ Declined

Does your child need or use **medical equipment** (such as, wheelchair, leg braces, nebulizer)?

○ Yes ○ No ○ I don't know ○ Declined

Is your child able to do the same things most children his/her age can do?

○ Yes ○ No ○ I don't know ○ Declined

Does your child need or get **special therapy**, like physical, occupational or speech therapy?

○ Yes ○ No ○ I don't know ○ Declined

Does your child need or get **treatment or counseling** for an emotional, developmental or behavioral problem?

○ Yes ○ No ○ I don't know ○ Declined

14. Has your child had the flu shot or flu mist this year?

○ Yes ○ No ○ I don't know ○ Declined

15. What is the level of stress in your child's everyday life?

- ○ Very high
- ○ High
- ○ Medium
- ○ Low
- ○ Other
- ○ I don't know
- ○ Declined

16. How does your child manage the day-to-day stress in his/her life?

- ○ They don't have any stress in their life
- ○ They try to relax or manage stress themselves
- ○ They are getting help from a professional
- ○ Other
- ○ Declined
- ○ They have stress in their life, but they can't seem to do anything about it
- ○ They take medications to manage stress
- ○ They are using alcohol to manage stress
- ○ I don't know

Child Health History

17. 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

18. Has your child's health caused them to miss time away from school, work or other activities within the last year?

○ Yes ○ No ○ I don't know ○ Declined

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

○ Does not apply ○ Yes ○ No. Go to question 20. ○ I don't know ○ Declined

Is your child pregnant?

○ Yes ○ No ○ I don't know ○ Declined

If yes, how long has she been pregnant?

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

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

○ Yes ○ No ○ I don't know ○ Declined

Who is your child's doctor?

City and/or County?

20. 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 ○ Declined

Stayed overnight in a hospital?

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

Child Health History

21. Over the last 2 weeks, how often has your child been bothered by any of the following?

Feeling sad, down, depressed or hopeless?

- ○ Not at all
- ○ Several Days
- ○ More than half the days
- ○ Nearly every day
- ○ I don't know
- ○ Declined

Having little or no pleasure in doing things?

- ○ Not at all
- ○ Several Days
- ○ More than half the days
- ○ Nearly every day
- ○ I don't know
- ○ Declined

Feeling nervous, anxious or on edge?

- ○ Not at all
- ○ Several Days
- ○ More than half the days
- ○ Nearly every day
- ○ I don't know
- ○ Declined

Not being able to stop or control worrying?

- ○ Not at all
- ○ Several Days
- ○ More than half the days
- ○ Nearly every day
- ○ I don't know
- ○ Declined

22. 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
- ○ I don't know
- ○ Declined

23. How often does your child use alcohol, drugs or medications (including prescriptions) which affect their mood or help them relax?

- ○ Daily
- ○ Almost every day
- ○ Sometimes
- ○ Rarely or never
- ○ I don't know
- ○ Declined

If the response is daily or almost every day only:

Has your child felt that they ought to cut down on their drinking or drug use?

- ○ Yes
- ○ No

Have people annoyed your child by criticizing their drinking or drug use?

- ○ Yes
- ○ No

Has your child felt bad or guilty about their drinking or drug use?

- ○ Yes
- ○ No

Has your child ever had a drink or used drugs first thing in the morning to steady their nerves or to get rid of a hangover (eye-opener)?

- ○ Yes
- ○ No

Child Health History

24. What percent of time does your child usually buckle their safety belt when riding in the car?

- ○ Never - 0 percent
- ○ Seldom - 1-39 percent
- ○ Sometimes - 40-79 percent
- ○ Usually - 80-99 percent
- ○ Always - 100 percent
- ○ I don't know
- ○ Declined

25. If your child rides a bicycle, motorcycle or other motorized vehicle (scooter, four wheeler), how often do they wear a helmet?

- ○ Sometimes or never
- ○ They don't ride any of these motorized vehicles.
- ○ Always or almost always
- ○ I don't know
- ○ Declined

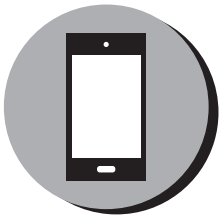
26. Does your child need help in any of the following areas?

- ○ 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
- ○ I don't know
- ○ Declined

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

Spanish: Español ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-325-8386. (TRS: 711: 1-866-591-2908).

Kurdish: کوردی ئەگەر بە کوردی سۆرانی قسە دەکەن، خزمەتگوزارییەکانی وەرگێران بەخۆڕایی دەخرێتە بەردەستتان. پەیوەندی بکەن بە ژمارە 1-888-325-8386 (TRS: 711: 1-866-591-2908) .



Do you need help with your health care, talking with us, or reading what we send you? Call us for free at 1-888-325-8386. We can connect you with the free help or service you need. (For TRS call: 1-866-591-2908)

We obey federal and state civil rights laws. We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. Do you think we did not help you or treated you differently? Then call CoverKids 1-888-325-8386 *(TRS 711) for free.

BlueCare Tennessee

kidcentral tn
KIDCENTRALTN.COM

BlueCare Tennessee
1 Cameron Hill Circle, Suite 73 | Chattanooga, TN 37402

bluecare.bcbst.com

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