

Health History and 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?

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
 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?

Pounds	
<input type="radio"/> 0	<input type="radio"/> 0
<input type="radio"/> 100	<input type="radio"/> 10
<input type="radio"/> 200	<input type="radio"/> 20
<input type="radio"/> 300	<input type="radio"/> 30
<input type="radio"/> 400	<input type="radio"/> 40
<input type="radio"/> 500	<input type="radio"/> 50
<input type="radio"/> 600	<input type="radio"/> 60
<input type="radio"/> 700	<input type="radio"/> 70
	<input type="radio"/> 80
	<input type="radio"/> 90

- I don't know
 Declined

9. How tall is your child?

Feet	Inches
	<input type="radio"/> 0
	<input type="radio"/> 1
<input type="radio"/> 2	<input type="radio"/> 2
<input type="radio"/> 3	<input type="radio"/> 3
<input type="radio"/> 4	<input type="radio"/> 4
<input type="radio"/> 5	<input type="radio"/> 5
<input type="radio"/> 6	<input type="radio"/> 6
<input type="radio"/> 7	<input type="radio"/> 7
	<input type="radio"/> 8
	<input type="radio"/> 9
	<input type="radio"/> 10
	<input type="radio"/> 11

- 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

Child Health History

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

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.

- | | |
|---|---|
| <input type="radio"/> Anxiety | <input type="radio"/> Asthma |
| <input type="radio"/> Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) | <input type="radio"/> Autism or Autism Spectrum Disorders |
| <input type="radio"/> Behavior or conduct problems | <input type="radio"/> Bipolar Disorder |
| <input type="radio"/> Brain Injury | <input type="radio"/> Cancer |
| <input type="radio"/> Heart conditions | <input type="radio"/> Depression |
| <input type="radio"/> Slow or Delayed Development | <input type="radio"/> Diabetes or sugar |
| <input type="radio"/> Low birth weight and or other birth problems | <input type="radio"/> Schizophrenia |
| <input type="radio"/> Sleep problems | <input type="radio"/> 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
 Does not apply
 Drink alcohol (more than a few sips)
 I don't know
 Smoke marijuana
 Declined
 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)

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
 - Sometimes - 40-79 percent
 - Always - 100 percent
 - Seldom - 1-39 percent
 - Usually - 80-99 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
 - Always or almost always
 - They don't ride any of these motorized vehicles.
 - 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 BlueCare 1-800-468-9698. Llame al TennCareSelect 1-800-263-5479 (TRS: 711: 1-888-418-0008).

Kurdish: کوردی ئه‌گهر به کوردی سۆرانی قسه ده‌که‌ن، خزمه‌تگوزارییه‌کانی وهرگیران به‌خۆراییی ده‌خه‌رتته به‌رده‌ستتان. په‌یوه‌ندی بکه‌ن به ژماره TennCareSelect 1-800-263-5479, BlueCare 1-800-468-9698 (TRS: 711: 1-888-418-0008).



Do you need help with your health care, talking with us, or reading what we send you? Call us for free at: BlueCare 1-800-468-9698 or TennCareSelect 1-800-263-5479 (TRS: 711 and ask for 888-418-0008).

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 BlueCare 1-800-468-9698, TennCareSelect 1-800-263-5479 or TennCare 1-855-857-1673 (TRS 711) for free.

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