Pediatric Health Risk Assessment Survey

BlueCross BlueShield Arizona
An Independent Licensee of the Blue Cross Blue Shield Association
Health Choice

Please complete the following questions the best that you can. The information will be used to provide resources on how to live a healthy life and prevent disease. Your answers will not affect your child's Medicaid benefits.

IMPORTANT: Be sure to complete your Child's Name and Member ID.
This information will help us know who your child is.

Member Name: _____ Date of Birth: _____

Medicaid ID Number: _____ Phone Number: _____

Address: _____

Primary Care Physician: _____ Current Date: _____

1. **Date of Completion?** _____

2. **Has your child been diagnosed with any of the following?**
   - ☐ Asthma
   - ☐ Diabetes
   - ☐ Cancer: Type _____
   - ☐ Autism/Autism Spectrum Disorder
   - ☐ Birth Defects: Type _____
   - ☐ Bronchitis
   - ☐ Down Syndrome
   - ☐ Epilepsy/Seizure Disorder
   - ☐ Heart Problems
   - ☐ Liver Disease
   - ☐ Kidney Disease
   - ☐ Sickle Cell Anemia
   - ☐ Learning Disabilities
   - ☐ Behavioral Health Condition: Diagnosis _____
   - ☐ Transplant: Organ _____
   - ☐ Other: _____

3. **Is your child currently taking any medications on a regular basis?**
   - ☐ Yes
     If Yes, what medications: _____
   - ☐ No

4. **Has your child had any Behavioral Health Issues that they have been seen by a doctor for?**
   - ☐ Yes
     If Yes, where have they been seen: _____
   - ☐ No

5. **How would you rate your child's health in the past 6 months?**
   - ☐ Excellent
   - ☐ Good
   - ☐ Fair
   - ☐ Sick occasionally
   - ☐ Sick more than most other children

6. **Has your child been hospitalized in the past 6 months?**
   - ☐ Yes
     If Yes, where and why: _____
   - ☐ No

7. **Has your child been in the Emergency Room in the past 6 months?**
   - ☐ Yes
     If Yes, where and why: _____
   - ☐ No

8. **Has your child's doctor ever told you that your child is overweight?**
   - ☐ Yes
   - ☐ No

9. **Is your child up to date on their immunizations?**
   - ☐ Yes
   - ☐ No
     If No, when was their last immunization? _____

10. **Was your child seen for a well visit within the past 12 months?**
    - ☐ Yes
    - ☐ No. If No, why not: _____
    - ☐ Lack of transportation
    - ☐ Unable to get off work
    - ☐ Unable to schedule an appointment with their doctor
    - ☐ Other: _____

11. Use this table to fill out questions about social and other needs for your child:

Food	
Within the past 12 months, did you worry that your food would run out before you got money to buy more and your child would go hungry?	☐ Yes ☐ No
Housing/Utilities	
Does your child have housing?	☐ Yes ☐ No
Are you worried about losing your housing?	☐ Yes ☐ No
Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed?	☐ Yes ☐ No
Transportation	
Within the past 12 months, has lack of transportation kept you from getting your child to medical appointments or non-medical meetings, work, or appointments, or kept you from getting their medicines or other things they need?	☐ Yes ☐ No
Interpersonal Safety	
Do you feel physically and emotionally safe where you currently live?	☐ Yes ☐ No
Within the past 12 months, has your child been hit, slapped, kicked, or otherwise physically hurt by someone?	☐ Yes ☐ No
Does your child attend school regularly?	☐ Yes ☐ No
Is your child exposed to others using drugs?	☐ Yes ☐ No
How many hours of sleep does your child get?	_____ hours

12. Do you have any other concerns about your child's development or any other topics?

_____

References:
Child Health Questionnaire, CHQ-PF50
www.brightfutures.org