PEDIATRIC HEALTH RISK ASSESSMENT SURVEY

Health CHOICE ARIZONA

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, getting their medicines, non-medical meetings or appointments, work, or from getting 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 concerns?

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