

# Enrollees with Special Health Care Needs

## PEDIATRIC Health Risk Assessment

Member Name: \_\_\_\_\_

Date form filled out: \_\_\_\_\_

Member Date of Birth: \_\_\_\_\_

Sex:            Female            Male

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1. Do you (or your child) currently need or use **medicine prescribed by a doctor** (other than vitamins) for ANY medical, behavioral or other health condition?

Yes ⇒ Go to Question 1a

No ⇒ Go to Question 2

a. Is this a condition that has lasted or is expected to last for **at least** twelve months?

Yes

No

2. Do you (or your child) need or use **more medical care or mental health services** than is usual for someone of your age for ANY medical, behavioral or other health condition?

Yes ⇒ Go to Question 2a

No ⇒ Go to Question 3

a. Is this a condition that has lasted or is expected to last for **at least** twelve months?

Yes

No

3. Are you (or your child) **limited or prevented** in any way to do the things most people of the same age can do because of ANY medical, behavioral or other health condition?

Yes ⇒ Go to Question 3a

No ⇒ Go to Question 4

3a. Is this a condition that has lasted or is expected to last for **at least** twelve months?

Yes

No

4. Do you (or your child) need or get **special therapy**, such as physical, occupational or speech therapy because of ANY medical, behavioral or other health condition?

Yes ⇒ Go to Question 4a

No ⇒ Go to Question 5

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4a. Is this a condition that has lasted or is expected to last for **at least** twelve months?

- Yes  
 No

5. Do you (or your child) have any kind of emotional or behavioral problem for which you need or get **treatment or counseling**?

- Yes ⇒ Go to Question 5a  
 No ⇒ Go to Question 6

5a. Has this problem lasted or is it expected to last for **at least** 12 (twelve) months?

- Yes  
 No

6. Are you (or your child) pregnant?

- Yes - Please call Community Health Plan at 1-800-440-1561 and ask to speak with the New Arrivals Program.  
 No

7. On a scale of 1-5, how much pain are you (or your child) experiencing today?

(no pain at all) 1 ---- 2 ---- 3 ---- 4 ---- 5 (a lot of pain)

8. On a scale of 1-5, how comfortable are you contacting your doctor if you (or your child) are experiencing pain or discomfort?

(Very comfortable) 1 ---- 2 ---- 3 ---- 4 ---- 5 (not comfortable at all)

9. Who is the doctor that you (or your child) see the most?

\_\_\_\_\_

10. Do you know your/your child's blood pressure?

- Yes ⇒ What is it usually? \_\_\_\_\_  
 No

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11. Do you (or your child) use a cane, walker, wheel chair, or other medical equipment?

- Yes If YES, Do you have stairs where you live? YES  NO   
 No

12. On a scale of 1-5, how well do you think your/your child's conditions are being treated?

(Very well) 1 ---- 2 ---- 3 ---- 4 ---- 5 (not well at all)

13. Do you live by yourself or with other people?

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14. In the past few weeks, how have you (or your child) been feeling physically and emotionally?

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15. On a scale of 1-5, how has your condition affected your/your child's work or school?

(Not affected at all) 1 ---- 2 ---- 3 ---- 4---- 5 (severely affected)

16. On a scale of 1-5 how has your condition affected your/your child's leisure time/social life?  
(For example going to church, going out with friends)

(Not affected at all) 1 ---- 2 ---- 3 ---- 4---- 5 (severely affected)

17. About your doctor:

A) Do you and your doctor talk about your/your child's plan for care?

- Yes  
 No => Why not? \_\_\_\_\_

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B) On a scale of 1-5, how satisfied are you with your/your child's plan for care?

(Very satisfied) 1 ---- 2 ---- 3 ---- 4 ---- 5 (very unsatisfied)

C) On a scale of 1-5, do you feel you participated with the doctor in making your/your child's plan for care?

(A lot) 1 ---- 2 ---- 3 ---- 4 ---- 5 (not at all)

18. Do you (or your child) have special therapy, or community services (other agency) help at home?

Yes ⇒ With whom? \_\_\_\_\_  
 No

19. Is it alright if we talk with your/your child's doctor about this information?

Yes  
 No ⇒ Why not? \_\_\_\_\_

20. Is there anything else we can help you with?

Yes Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

No