

Child Health Demographics Form

Date

Personal Information				
Child's name (Last, First, Middle)		Date of Birth		
Suffix		S.S.#		
Title XIX#		Gender		
Referral Source (circle one)		Agency home Admit	Discharge	
Care coordinator	Medical Clinic	Admission reason Moved New Re-admittance Requested transfer	Discharge reason Age restriction Goals met Income guideline restriction Lost to Follow-up Moved Non-compliance Population-Based Service Only	
Child care	Other agency			Re-inform unsuccessful
Church	Other participant			Requested discharge
DHS	Outreach			Selected non-contract HMO
Door to door	Primary care provider			Unreachable/ Unavailable
Family Planning	School/AEA			Refusal of services
Friend/Relative	Shelter			
Hospital	Walk-in/Self referral			
Juvenile court officer	WIC			
Other Programs (circle all that apply)				Notes:
1 st Five	Family planning			
Before/After school care	<i>hawk-i</i>			
CH Specialty Clinics	Head Start			
Child Care	School fluoride rinse			
Early Head Start	School sealant			
EPSDT	WIC			

Ethnicity & Language Information						
Ethnicity Hispanic Not Hispanic			Country of origin			
All Races (Select all that apply)			Primary race			
American Indian or Alaska Native			Needs translator Yes No			
Asian			Primary Language			
Black or African American			Secondary Language			
Native Hawaiian or Other Pacific Islander						
White						
Languages						
American Sign Language	Chinese, Cantonese	Greek	Karenni	Oromic	Slovak	Ukrainian
Amharic	Chinese, Mandarin	Guijarati	Kikuyu	Pingelap	Somali	Urdu
Arabic	Croatian	Hebrew	Kirundi	Polish	Spanish	Vietnamese
Armenian	Czech	Hindi	Korean	Portuguese	Sudanese	Yiddish
Bambara	Dinka	Hmong	Krah	Romanian	Swahili	Yoruba
Bengali	Dutch	Hungarian	Kunama	Rundi	Swedish	Other
Bosnian	English	Iiocano	Laotian	Russian	Tagalog	
Burmese	Farsi (Persian)	Indonesian	Luo	Samoan	Thai	
Cambodian (Khmer)	French	Italian	Marshallese	Serbian	Tigrinya	
Chamorro	Ga	Japanese	Nepali	Shan	Tongan	
Chin	German	Karen	Nuer	Shona	Turkish	

Family & Household Information					
Address 1			Zip		
Address 2			Family size	Monthly income	
Primary phone <u>C</u> <u>E</u> <u>H</u> <u>P</u> <u>R</u> <u>W</u> ()	Secondary phone <u>C</u> <u>E</u> <u>H</u> <u>P</u> <u>R</u> <u>W</u> ()	Email address			
<u>C</u> ellular	<u>E</u> mergency	<u>H</u> ome	<u>P</u> ager	<u>R</u> elative	<u>W</u> ork

Child Health Demographics Form (Continued)

Child's name	Date of Birth	Title XIX#
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Parent & Guardian Information		
Custodial parent's marital status (circle one) <div style="display: flex; justify-content: space-around; font-size: small;"> Divorced Married Parent w/ partner Separated Single Widowed </div>		
Mother (Last, First, Middle)	Suffix	Education level achieved (circle one)
		<div style="display: flex; justify-content: space-between; font-size: x-small;"> <div>Grade School (or less) Middle School High School</div> <div>Associate's degree Vocational/Trade school Bachelor's degree (or beyond) No Formal Education</div> </div>
Father (Last, First, Middle)	Suffix	Education level achieved (circle one)
		<div style="display: flex; justify-content: space-between; font-size: x-small;"> <div>Grade School (or less) Middle School High School</div> <div>Associate's degree Vocational/Trade school Bachelor's degree (or beyond) No Formal Education</div> </div>
Guardian (Last, First, Middle)	Suffix	Education level achieved (circle one)
		<div style="display: flex; justify-content: space-between; font-size: x-small;"> <div>Grade School (or less) Middle School High School</div> <div>Associate's degree Vocational/Trade school Bachelor's degree (or beyond) No Formal Education</div> </div>

Medical Home Information		
Does the client have a usual source of medical care?	Yes No	Primary Care Provider
Is the usual source of medical care available 24/7?	Yes No	Name
Does the source of care maintain the client's record?	Yes No	County of Licensure
Client has medical insurance?	Yes No	Date of last visit (mm/dd/yyyy)
Medical Barriers (circle all that apply)		
Child care for siblings Cost	Language Location of provider	No Medical Home Provider declines insurance
Fear of medical procedures	No barriers	Transportation
Hours of appointment	No belief in preventive health care	Unaware of need for well visit
		Unpaid bill at office

Dental Home Information		
Does the client have a usual source of dental care?	Yes No	Dentist
Does the usual source of dental care maintain the client's record?	Yes No	Name
Has the client seen a dentist within the past 12 months?	Yes No	County of Licensure
Client has dental insurance?	Yes No	
Dental Barriers (circle all that apply)		
Child care for siblings Dentist will not see children under 4 years of age Dentist declines insurance Fear of dental procedures	Hours of appointment Language Location of dentist No barriers	No belief in preventive dental care Transportation Unaware of need for well visit Unpaid bill at office
		Cost
Dental Risk Assessment		
Screening Date	Decayed Teeth Yes No	Filled Teeth Yes No
		Sealed Teeth Yes No
		Risk Level Low Moderate High

Early ACCESS		
Client has a developmental delay or disability?	Yes No	Delay Types (circle all that apply)
Client has a condition known to have a high probability of later delays in development?	Yes No	Adaptive Cognitive Communication Emotional Health Status
Client has an IFSP (Individual Family Service Plan)?	Yes No	Hearing Physical Social Vision