Children with Special Health Care Needs Screener (CSHCNS)

Patient Name: _____ Birth Month/Year: _____/_____

1. Does your child currently need or use **medicine prescribed by a doctor** (other than vitamins)?

☐ Yes Go to Question 1a ☐ No Go to Question 2

1a. Is this because of ANY medical, behavioral or other health condition?

☐ Yes Go to Question 1b ☐ No Go to Question 2

1b. Is this a condition that has lasted or is expected to last for at least 12 months?

☐ Yes ☐ No

2. Does your child need or use more **medical care, mental health, or educational services** than is usual for most children of the same age?

☐ Yes Go to Question 2a ☐ No Go to Question 3

2a. Is this because of ANY medical, behavioral or other health condition?

☐ Yes Go to Question 2b ☐ No Go to Question 3

2b. Is this a condition that has lasted or is expected to last for at least 12 months?

☐ Yes ☐ No

3. Is your child **limited or prevented** in any way in his or her ability to do the things most children of the same age can do?

☐ Yes Go to Question 3a ☐ No Go to Question 4

3a. Is this because ANY medical, behavioral or other health condition?

☐ Yes Go to Question 3b ☐ No Go to Question 4

3b. Is this a condition that has lasted or is expected to last for at least 12 months?

☐ Yes ☐ No

4. Does your child need or get **special therapy**, such as physical, occupational or speech therapy?

☐ Yes Go to Question 4a ☐ No Go to Question 5

4a. Is this because ANY medical, behavioral or other health condition?

☐ Yes Go to Question 4b ☐ No Go to Question 5

4b. Is this a condition that has lasted or is expected to last for at least 12 months?

☐ Yes ☐ No

5. Does your child have any kind of emotional, developmental or behavioral problem for which he or she needs or gets treatment or counseling?

☐ Yes Go to Question 5a ☐ No

5a. Has this problem lasted or is expected to last for at least 12 months?

☐ Yes ☐ No

6. Please describe your child's medical, behavioral, emotional, developmental, health condition or problem

☐ Negative ☐ Positive