

SOUTH LOS ANGELES BEST BABIES COLLABORATIVE

Case Management Risk Assessment Tool- Pregnant Clients

For clients who are currently pregnant

Assessment Completion Date: _____

Initial _____ / _____
(1st OB) Date Weeks

2nd Trimester _____ / _____
(14-27 wks) Date Weeks

Third Trimester _____ / _____
(28 wks-Delivery) Date Weeks

Case Manager: _____ Date Referred: _____

Source of Referral:

Inreach Outreach Other Collaborative Agency Other Non-Collaborative Agency

Intake Date: _____ Medical Records Requested on _____

from _____ date

provider name

Personal Information

1. Patient Name: _____ 2. Date of Birth: _____

3. Address: _____ City and Zip Code: _____

Secondary Address: _____ City and Zip Code: _____

4. Telephone Number home: _____ work: _____ cell: _____

5. Emergency Telephone Number: _____ Relationship to Emergency Contact: _____

6. Social Security Number: _____

7. WIC Family ID#: _____

8. Do you have health insurance? Yes No
If Yes, Health Plan: _____ Identification No: _____

9. Do all of your children under the age of 18 have health insurance? Yes No
If Yes, Health Plan(s): _____

If No, how many children do NOT have health insurance? _____

10. OB Provider Name: _____

11. Delivery Hospital Name and Location: _____

12. Race/Ethnicity:

African American Hispanic Asian/Pacific Islander White

Other: _____

13. Are you: Single Married Divorced Widowed Common Law Marriage
 Other _____

14. Were you born in the U.S.? Yes No If no, where were you born? _____

15. How long have you lived in the U.S.? _____ Years _____ Months

16. What is your immigration status? _____

17. Do you plan to stay in this area for the rest of your pregnancy? _____

18. Years of education completed: 0-8 years 9-11 years 12-16 years 16+ years

19. Which of the following best describes how you read:
 Like to read and read often Can read, but read slowly or not very often Do not read

20. What language do you prefer to read: English Spanish Other: _____

21. What language do you prefer to speak: English Spanish Other: _____

Economic Resources

22. Are you currently working? Yes No
 If Yes, hours per week: _____
 Type of work: _____

23. Do you plan to work while you are pregnant? No Yes How long? _____
 Type of work: _____

24. Are you currently going to school? No Yes Type: _____ Hr/Wk: _____
 Cal Learn? Yes No

25. Do you plan to go to school while you are pregnant? No Yes How long? _____
 Type of school: _____

26. Will the father of the baby provide financial support to you and the baby? Yes No
 Other sources of financial help? _____

27. Are you receiving any of the following? (Check all that apply.)

	0-13 wks		14-27 wks		28-40 wks		Referral Date
	Yes	No	Yes	No	Yes	No	
a. WIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
b. Food Stamps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
c. AFDC/TANF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
d. Emergency Food Assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
e. Insurance Benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
f. Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

28. Do you have enough clothes/food for yourself and your family?

	0-13 wks		14-27 wks		28-40 wks	
	Yes	No	Yes	No	Yes	No
Clothes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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29. Do you or others in your home ever skip meals?

0-13 wks		14-27 wks		28-40 wks	
Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Why? **0-13 wks:** _____
14-27 wks: _____
28-40 wks: _____

30. Do you ever run out of food before the end of the month?

0-13 wks		14-27 wks		28-40 wks	
Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Housing

31. What type of housing do you currently live in? House Apartment Trailer Park
 Hotel/Motel Farm Worker Camp Emergency Shelter Car
 Other: _____

Any Changes? No Yes **14-27 wks:** _____
 No Yes **28-40 wks:** _____

32. Who lives with you in your home?

Name	Relationship	Age	Name	Relationship	Age
a.			e.		
b.			f.		
c.			g.		
d.			h.		

33. Which of the following do you have where you live? (Check all that apply.)

0-13 wks: toilet stove/place to cook tub/shower electricity hot/cold water phone
14-27 wks: toilet stove/place to cook tub/shower electricity hot/cold water phone
28-40 wks: toilet stove/place to cook tub/shower electricity hot/cold water phone

34. Do you feel your current housing meets your basic needs? Yes No, please explain: _____

35. Do you feel safe in your home? Yes **0-13 wks** Yes **14-27 wks** Yes **28-40 wks**

No **0-13 wks**, please explain: _____
 No **14-27 wks**, please explain: _____
 No **28-40 wks**, please explain: _____

36. If there are guns in your home, how are they stored? _____

37. Do any of your children or your partner's children live with someone else? N/A No

If Yes, please explain: _____

Pt. Name: _____
Date of Birth: _____
Health Plan: _____
Identification No: _____

38. Will you have problems keeping your appointments/attending classes?

No 0-13 wks

No 14-27 wks

No 28-40 wks

Yes **0-13 wks:**

Transportation

Child Care

Work

School

Other

Yes **14-27 wks:**

Transportation

Child Care

Work

School

Other

Yes **28-40 wks:**

Transportation

Child Care

Work

School

Other

39. When you ride in a car, how often do you use seat belts?

Never

Sometimes

Always

40. Will you be able to get a car safety seat for the new baby by the time the baby is born?

Yes

No

41. How will you get to the hospital?

14-27 wks: _____

28-40 wks: _____

Pregnancy History and Care

42. Is this your first pregnancy?

Yes

No

43. How many pregnancies have you had? _____

44. How many of these pregnancies were:

Full Term _____

Pre-Term _____

Low Birth Weight _____

(20-37 wks)

(< 5.5 lbs.)

45. Was this pregnancy planned?

Yes

No

46. How do you feel about being pregnant now?

0-13 wks:

Good

Troubled

please explain: _____

14-27 wks:

Good

Troubled

please explain: _____

28-40 wks:

Good

Troubled

please explain: _____

47. What is the name of the father of the baby? _____

48. How old is the father of the baby?

If the client is a minor and the father of the baby is an adult, please report to the proper authorities

Date of report: _____

Agency Contacted: _____

Contact person to follow up with case: _____

49. Are you considering: adoption?

Yes No

abortion?

Yes No

If Yes, do you need information/referrals?

Yes

No

50. Do you feel anxious about having this baby and/or caring for this baby?

Yes

No

If Yes, why? _____

51. How does the father of the baby feel about this pregnancy? _____

a. Your family? _____

b. Your friends? _____

Pt. Name: _____
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52. Have you had any losses in past pregnancies such as:

	Yes	No	Date:
Miscarriages (prior to 20 wks)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stillborn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Adoption	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abortion	<input type="checkbox"/>	<input type="checkbox"/>	_____
Therapeutic abortion	<input type="checkbox"/>	<input type="checkbox"/>	_____
SIDS	<input type="checkbox"/>	<input type="checkbox"/>	_____

If yes, what/who helped you get through this? _____

53. If you had other children, are they still living? Yes No N/A

If no, please explain: _____

54. If you had a baby before, where was that baby(s) delivered?

Hospital Clinic Home Other: _____

Were there any problems? Yes No

If Yes, please explain: _____

55. What is the EDD based on date of last menstrual period? _____

56. EDD based on ultrasound: _____

57. Do you have any of these medical risk factors? (check all that apply)

- ≤ 19 years old first pregnancy ≥ 35 years old Type 1 diabetes
 Type 2 diabetes current or hx of gestational diabetes hypertension
 hx of pregnancy related hypertension other: _____

58. How often do you follow the recommendations from your doctor or healthcare provider?

- Always Most of the time Sometimes Rarely Never

59. Does the doctor say there are any problems with this pregnancy?

14-27 wks: No If Yes, please describe: _____

28-40 wks: No If Yes, please describe: _____

60. Are you scheduled for any tests?

14-27 wks: No If Yes, please describe: _____

28-40 wks: No If Yes, please describe: _____

Pt. Name: _____
Date of Birth: _____
Health Plan: _____
Identification No: _____

61. Do you have any of the following problems now? (check all that apply)

	<u>0-13 wks</u>		<u>14-27 wks</u>		<u>28-40 wks</u>	
	Yes	No	Yes	No	Yes	No
a. Swelling of hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Fatigue/sleeping problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Vaginal discharge/bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Abdominal cramping/contractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

m. Other: _____

62. Do you plan to have someone with you:

	<u>14-27 wks</u>			<u>28-40 wks</u>		
	a. During labor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Do not know	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. When you first come home with the baby?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Do not know	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Do not know

63. Besides having a healthy baby, what are your goals for this pregnancy? _____

64. Do you have any traditional, cultural, or religious customs about pregnancy and childbirth you would like supported? Yes No

Please explain: _____

65. In comparison to your previous pregnancies, is there anything you would like to change about the care you receive? Yes No

Please explain: _____

66. Who gives you the most advice about your pregnancy? _____

67. What have you been told that you think is important? _____

Pt. Name: _____
Date of Birth: _____
Health Plan: _____
Identification No: _____

68. Do you have any questions about your pregnancy? _____

69. Would you like to have another child? Yes No
If yes, when? _____

70. Do you plan to use a method of birth control after this pregnancy?

14-27 wks: Yes No Undecided If Yes, what method? IUD
 Birth control pills Calendar/rhythm Condom Diaphragm
 Patch Abstinence Natural Family Planning Foam
 Tubal/Vasectomy DepoProvera Nuva Ring Norplant

28-40 wks: Yes No Undecided If Yes, what method? IUD
 Birth control pills Calendar/rhythm Condom Diaphragm
 Patch Abstinence Natural Family Planning Foam
 Tubal/Vasectomy DepoProvera Nuva Ring Norplant

71. Do you practice safe sex? Yes No
If yes, what methods do you use? _____

72. Your current or past behaviors, or the current or past behaviors of your sexual partner(s) may place you at risk for being/becoming infected with HIV, the virus which causes AIDS. Since 1990, have you or any of your sexual partner(s):

	<u>Self</u>	<u>Partner</u>	<u>Unknown</u>	<u>No</u>
Had sex with more than one partner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had sex with someone you/they didn't know well?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been treated for trichomonas, chlamydia, genital warts, syphilis, gonorrhea, or other sexually transmitted infections?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had sex with someone who used drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had hepatitis B?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shared needles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had a blood transfusion since 1979?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

73. Is there any other reason you think you might be at risk for HIV/AIDS? Yes No
If Yes, please explain: _____

74. Change in HIV/AIDS risk status? **14-27 wks:** No Yes, what? _____

28-40 wks: No Yes, what? _____

75. Have you been offered counseling/information on the benefits of HIV testing and been offered a blood test for HIV?

0-13 wks: Yes No (Refer to OB provider)

14-27 wks: Yes No (Refer to OB provider)

28-40 wks: Yes No (Refer to OB provider)

If Yes, do you have any questions? _____

Pt. Name: _____
Date of Birth: _____
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Current Health Practices and Status

76. Do you currently have a doctor? Yes No

77. Do your children have a doctor? Yes No

78. Do you know how to find a doctor for you and your family? Yes No explain: _____

79. Would you like assistance finding a doctor for you or your family? Yes No

80. Do you have a doctor for your baby? **14-27 wks:** Yes No Who? _____
28-40 wks: Yes No Who? _____

81. Have you been to a dentist in the last year? Yes No
 Any dental problems? No Yes, please describe: _____
 If Yes, did you get treatment for these problems? No Yes, please describe: _____
 If no, why didn't you get treatment? _____

82. Do you need assistance finding a dentist or dental insurance? Yes No

83. On average, how many total hours a night do you sleep?
0-13 wks: _____ **14-27 wks:** _____ **28-40 wks:** _____

84. On average, how many hours do you nap a day?
0-13 wks: _____ **14-27 wks:** _____ **28-40 wks:** _____

85. What do you do for exercise? _____ How often? _____

86. Do you have exposure to chemicals:

	0-13 wks:		14-27 wks		28-40 wks		
	Yes	No	Yes	No	Yes	No	
a. At work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what? _____
b. At home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what? _____
c. With hobbies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what? _____

87. Do you smoke cigarettes?
0-13 wks: Yes No How many per day? _____ For how many years? _____
14-27 wks: Yes No How many per day? _____ For how many years? _____
28-40 wks: Yes No How many per day? _____ For how many years? _____

88. Are you exposed to secondhand smoke at home or at work?

89. Are you using chewing tobacco?

0-13 wks:		14-27 wks		28-40 wks	
Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Pt. Name: _____
Date of Birth: _____
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90. If you smoke cigarettes or chew tobacco, have you:

- Considered quitting
- Set a definite date to quit
- Decided to cut down
- Decided not to quit at this time

91. How often do you drink alcohol (beer, wine, wine coolers, hard liquor, mixed drinks)?

- Daily
- Weekends
- 1-2 times per month
- Rarely or never

92. Have your alcohol habits changed since you got pregnant?

- Yes
- No

If yes, how? _____

93. Are you interested in stopping or cutting down while you are pregnant?

- Yes
- No

94. In your home, how do you store:

- Vitamins _____
- Medications _____
- Cleaning Agents: _____

95. Within the last 6 months, have you used any prescription medications?

For example prenatal vitamins, iron, allergy medication, Aldomet®, Prozac®, other?

0-13 wks: None Yes: _____

14-27 wks: None Yes: _____

28-40 wks: None Yes: _____

96. Since you became pregnant have you used any over-the-counter medications?

For example Tylenol®, Tums®, Sudafed®, laxatives, appetite suppressants, aspirin, other?

0-13 wks: None Yes: _____

14-27 wks: None Yes: _____

28-40 wks: None Yes: _____

97. Do you use any natural or herbal remedies (ginseng, manzanilla, greta, magnesium, yerba buena, other)?

0-13 wks: None Yes: _____

14-27 wks: None Yes: _____

28-40 wks: None Yes: _____

98. Within the last 6 months, have you used street drugs (marijuana, cocaine, PCP, crack, speed, crank, ice, heroin,

0-13 wks: None Yes: If yes, what? _____ How often? _____

14-27 wks: None Yes: If yes, what? _____ How often? _____

28-40 wks: None Yes: If yes, what? _____ How often? _____

99. If you use drugs, are you interested in quitting?

- Yes
- No

100. Have you tried to quit?

- Yes
- No

comments: _____

Pt. Name: _____
Date of Birth: _____
Health Plan: _____
Identification No: _____

101. Has your doctor ever told you that you have diabetes? Yes No

If Yes, when? _____

If Yes, did you eat before you took the test for diabetes? Yes No

102. Has your doctor ever told you that you have high blood pressure? Yes No

If yes, when? _____

Educational Interests

103. Do you have experience with or have you received education in any of the following topics in the past? (Column A). Would like additional information during this pregnancy (Column B) Both columns may be marked:

Topic	0-13 wks		14-27 wks		28-40 wks		Educational Materials Provided		
	A	B	A	B	A	B	Date	Code*	Initials
How your baby grows (fetal development)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
How your body changes during pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Healthy habits for a healthy pregnancy/baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Assistance with cutting down/quitting smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
What happens during labor and delivery/hospital tour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Helping your child(ren) get ready for a new baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
How to take care of yourself after the baby comes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
How to take care of your baby/infant safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
How to avoid sexually transmitted infections/HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

Teaching Codes: **A**= Answered questions
W=Written material provided

E=Explained verbally
S=Visual aids shown

V=Video shown
I=Interpreter

Pt. Name: _____
Date of Birth: _____
Health Plan: _____
Identification No: _____

104. Is there anything special you would like to learn about? _____

105. How do you like to learn new things? Read Talk one-on-one Watch a video
 Group education Pictures and diagrams Being shown how to do it
 Other: _____

106. Will someone be able to attend classes with you? Yes No Who? _____

107. Do you have any mental, emotional, or physical conditions, such as learning disabilities, Attention Deficit Disorder, depression, hearing, or vision problems, that may affect the way you learn?
 Yes No If yes, please explain: _____

Nutrition

108. Height without shoes (feet/inches): _____

109. What is your current weight? _____

110. What was your weight right before you became pregnant (pre-gravid)? _____

111. What was your weight at your first prenatal care appointment? _____

112. Since you have been pregnant, have you ever gained 8 or more pounds in a one month period? Yes No

113. Do you have any questions or concerns about your weight and/or weight gain during pregnancy? Yes No

If yes, please explain: _____

114. Are there any foods that you are avoiding? Yes No

If yes, which foods? _____

Why are you avoiding these? _____

115. Are you able to tolerate (digest) milk or dairy products? Yes No

116. Did your doctor tell you to take any vitamins or supplements? Yes No

If yes, which vitamins/supplements? _____

117. Do you take a prenatal vitamin every day? Yes No

If no, why not? _____

118. Do you take a folic acid supplement every day? Yes No

If no, why not? _____

Pt. Name: _____
Date of Birth: _____
Health Plan: _____
Identification No: _____

119. Do you take iron every day? Yes No
If no, why not? _____

120. Which other vitamins/supplements do you take? _____
How often? _____

121. How many meals do you eat per day? _____

122. How would you describe your appetite? Good Fair Poor
If Poor, why do you think it might be poor? _____

123. Have your eating habits changed since you've been pregnant?
0-13 wks: No Yes If yes, why?: _____

14-27 wks: No Yes If yes, why?: _____

28-40 wks: No Yes If yes, why?: _____

124. How much of the following do you drink per day? Water: _____ Milk: _____ Juice: _____
 Decaf. Coffee: _____ Coffee: _____ Punch, Kool Aid, Tang: _____ Herb Tea: _____
 Soda: _____ Diet Soda: _____

14-27 wks: Has this changed? No Yes, how? _____

28-40 wks: Has this changed? No Yes, how? _____

125. Who usually does the following in your home? Buys food: _____ Prepares food: _____

126. Have you had cravings or eaten any of the following? (Check all that apply) Yes No
 laundry starch freezer frost corn starch clay paste plaster dirt other: _____

127. If you have other children, did you breastfeed, or try to breastfeed them? Yes No
Did you have trouble breastfeeding? Yes No How long did you breastfeed? _____

128. How are you planning to feed your new baby? Breast Formula
 Both breast and formula Do not know Other: _____

Pt. Name: _____
Date of Birth: _____
Health Plan: _____
Identification No: _____

Coping Skills

129. Are you currently having problems/concerns with any of the following: **(check all that apply)**

	<u>0-13 wks</u>	<u>14-27 wks</u>	<u>28-40 wks</u>
None	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Divorce/Separation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recent death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illness (TB, cancer, abn. pap smear)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unemployment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immigration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Probation/parole	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child Protective Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____ Other: _____ Other: _____

130. Have you been incarcerated in the past six months? Yes No

131. Has your husband/boyfriend/partner been incarcerated in the past six months? Yes No

132. Has the father of your child been incarcerated in the past six months? Yes No

133. What things in your life do you feel good about?

0-13 wks: _____

14-27 wks: _____

28-40 wks: _____

134. What things in your life would you like to change?

0-13 wks: _____

14-27 wks: _____

28-40 wks: _____

Pt. Name: _____
Date of Birth: _____
Health Plan: _____
Identification No: _____

135. Are you happy with your current weight? Yes If No, please explain: _____

136. What do you do when you are upset? _____

137. In the past month, how often have you felt that you could not control the important things in your life?

- Very often Often Sometimes Rarely Never

138. Do you ever get depressed? Yes No

139. Have you ever felt so bad you planned or attempted suicide? Yes No

140. Is there anyone you can turn to for help and encouragement? (examples: parents, siblings, friends, boyfriend, etc..)

- No Yes If yes, who? _____
-

141. Which of the following SLABBC Social Support groups would you like to attend? (Check all that apply.)

- Women's Health Community Resources Healthy Births Basics Managing Chronic Diseases
 Family Safety Substance Abuse New Born Care/Parenting Cultural Beliefs
 Breastfeeding Family Planning Mental Health Weight Management and Nutrition

142. What do you or your partner do when you have disagreements? _____

143. Does anyone in your family use drugs and/or alcohol? Yes No

If yes, does this create problems for you? Yes No

If yes, please explain: _____

144. Do you ever feel afraid or threatened by your partner? Yes No

If yes, please explain: _____

145. Within the last year, have you or your children been hit, slapped, kicked, choked, or physically hurt by someone?

- No Yes If yes, who? Husband Ex-husband Boyfriend
 Partner Stranger Multiple Other: _____

Total number of times: _____

Please explain: _____

Pt. Name: _____
Date of Birth: _____
Health Plan: _____
Identification No: _____

146. Since you have been pregnant, have you been hit, slapped, kicked, choked or physically hurt by someone?

0-13 wks: No Yes If yes, by who? Husband Ex-husband Boyfriend

Partner Stranger Multiple Other: _____

Total number of times: _____

Please explain: _____

14-27 wks: No Yes If yes, by who? Husband Ex-husband Boyfriend

Partner Stranger Multiple Other: _____

Total number of times: _____

Please explain: _____

28-40 wks: No Yes If yes, by who? Husband Ex-husband Boyfriend

Partner Stranger Multiple Other: _____

Total number of times: _____

Please explain: _____

147. Within the last year has anyone forced you to have sexual activities?

0-13 wks: No Yes If yes, who? Husband Ex-husband Boyfriend

Partner Stranger Multiple Other: _____

Total number of times: _____

Please explain: _____

14-27 wks: No Yes If yes, who? Husband Ex-husband Boyfriend

Partner Stranger Multiple Other: _____

Total number of times: _____

Please explain: _____

28-40 wks: No Yes If yes, who? Husband Ex-husband Boyfriend

Partner Stranger Multiple Other: _____

Total number of times: _____

Please explain: _____

148. Are your children, or have your children been victims of violence or sexual abuse? Yes No

If Yes, please explain: _____

149. Have you ever talked to a counselor? Yes No

If Yes, please explain: _____

150. Would you feel comfortable talking to a counselor if you had a problem? Yes No

If No, why? _____

Pt. Name: _____
Date of Birth: _____
Health Plan: _____
Identification No: _____

Initial Assessment Completed by:

Name and Title	Initials	Date	Minutes
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Second Trimester Reassessment Completed by:

Name and Title	Initials	Date	Minutes
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Third Trimester Reassessment Completed by:

Name and Title	Initials	Date	Minutes
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Please note: Highlighted selections are optional.

Pt. Name: _____
Date of Birth: _____
Health Plan: _____
Identification No: _____