SOUTH LOS ANGELES BEST BABIES COLLABORATIVE

Case Management Risk Assessment Tool- Interconception Care

For clients who are not currently pregnant

Assessment Completion Date: ____________________

Initial______________ Date (MM/DD/YY)

1st Follow Up_____________ Date (MM/DD/YY)

2nd Follow Up_____________ Date (MM/DD/YY)

Case Manager: ____________________ Date Referred: ____________________

Source of Referral:
□ Inreach □ Outreach □ Other Collaborative Agency □ Other Non-Collaborative Agency

Intake Date: ____________________ Medical Records Requested on ____________________ date

from ____________________ 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: ____________________
Does your health insurance cover prenatal care? □ Yes □ No □ Unknown
Does your health insurance cover a pre-pregnancy and family planning visit? □ Yes □ No □ Unknown

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. Race/Ethnicity:

□ African American □ Hispanic □ Asian/Pacific Islander □ White

□ Other: ____________________

11. Are you: □ Single □ Married □ Divorced □ Widowed □ Common Law Marriage
□ Other ____________________

12. Were you born in the U.S.? □ Yes □ No If no, where were you born? ____________________

13. How long have you lived in the U.S.? ______________ Years ______________ Months

14. What is your immigration status? ____

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

16. 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

17. What language do you prefer to read: ☐ English ☐ Spanish ☐ Other: ______________

18. What language do you prefer to speak: ☐ English ☐ Spanish ☐ Other: ______________

Economic Resources

19. Are you currently working? ☐ Yes ☐ No
If yes, hours per week: ______________________________
Type of work: ______________________________

20. Are you currently going to school? ☐ No ☐ Yes Type: ______________ Hr/Wk: ______________
Cal Learn? ☐ Yes ☐ No

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

	Initial		**1st Follow Up**		**2nd Follow Up**		**Referral Date**
	Yes	No	Yes	No	Yes	No	
a. WIC	☐	☐	☐	☐	☐	☐	
b. Food Stamps	☐	☐	☐	☐	☐	☐	
c. AFDC/TANF	☐	☐	☐	☐	☐	☐	
d. Emergency Food Assistance	☐	☐	☐	☐	☐	☐	
e. Insurance Benefits	☐	☐	☐	☐	☐	☐	
f. Other:	☐	☐	☐	☐	☐	☐	

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

	Initial		**1st Follow Up**		**2nd Follow Up**	
	Yes	No	Yes	No	Yes	No
Clothes	☐	☐	☐	☐	☐	☐
Food	☐	☐	☐	☐	☐	☐

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

Initial		**1st Follow Up**		**2nd Follow Up**	
Yes	No	Yes	No	Yes	No
☐	☐	☐	☐	☐	☐

Why? **Initial:** ______________________________
1st Follow Up: ______________________________
2nd Follow Up: ______________________________

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

Initial		**1st Follow Up**		**2nd Follow Up**	
Yes	No	Yes	No	Yes	No
☐	☐	☐	☐	☐	☐

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

Housing

25. 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 **1st Follow Up:** ______________________________
☐ No ☐ Yes **2nd Follow Up:** ______________________________

26. Who lives with you in your home?

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

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

Initial: ☐ toilet ☐ stove/place to cook ☐ tub/shower ☐ electricity ☐ hot/cold water ☐ phone
1st Follow Up: ☐ toilet ☐ stove/place to cook ☐ tub/shower ☐ electricity ☐ hot/cold water ☐ phone
2nd Follow Up: ☐ toilet ☐ stove/place to cook ☐ tub/shower ☐ electricity ☐ hot/cold water ☐ phone

28. Do you feel your current housing meets your basic needs? ☐ Yes ☐ No, please explain: ______________________________

29. Do you feel safe in your home? ☐ Yes Initial ☐ Yes 1st Follow Up ☐ Yes 2nd Follow Up
☐ No **Initial**, please explain: ______________________________
☐ No **1st Follow Up**, please explain: ______________________________
☐ No **2nd Follow Up**, please explain: ______________________________

30. If there are guns in your home, how are they stored? ______________________________

31. Do any of your children or your partner's children live with someone else? ☐ N/A ☐ No
If yes, please explain: ______________________________

32. Will you have problems keeping your appointments/attending classes?
☐ No Initial ☐ No 1st Follow Up ☐ No 2nd Follow Up

☐ Yes **Initial**: ☐ Transportation ☐ Child Care ☐ Work ☐ School ☐ Other: __________
☐ Yes **1st Follow Up:** ☐ Transportation ☐ Child Care ☐ Work ☐ School ☐ Other: __________
☐ Yes **2nd Follow Up**: ☐ Transportation ☐ Child Care ☐ Work ☐ School ☐ Other: __________

33. When you ride in a car, how often do you use seat belts? ☐ Never ☐ Sometimes ☐ Always

Sexual and Pregnancy History

34. Are you sexually active? ☐ No ☐ Yes

35. Have you ever been pregnant? ☐ No ☐ Yes
If yes, how many pregnancies have you had? ______________________________

36. How many of these pregnancies were: Full Term __________ Pre-Term __________ (20-37 wks) Low Birth Weight __________ (< 5.5 lbs.)

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

37. Have you had any losses in past pregnancies such as:

	Yes	No	Date:
Miscarriages (prior to 20 wks)	◻	◻	________
Stillborn	◻	◻	________
Adoption	◻	◻	________
Abortion	◻	◻	________
Therapeutic abortion	◻	◻	________
SIDS	◻	◻	________

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

____

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

If no, please explain: ______________________________

____

39. 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: ______________________________

____

Did you have a postpartum check-up after your last pregnancy? ◻ Yes ◻ No

If no, why not? ______________________________

40. Do you have a child with a disability or special needs? ◻ Yes ◻ No

If yes, what is your child's diagnosis? ______________________________

Is your child receiving any support services, such as case management services? ◻ Yes ◻ No

If yes, what agency is providing these services? ______________________________

41. Do you have a family history of disabilities? ◻ Yes ◻ No

If yes, what? ______________________________

____

42. Would you like to have another child? ◻Yes ◻ No

If yes, when? ______________________________

If no, are you using birth control? ◻Yes ◻ No

If yes, what method of birth control are you using?

Initial Assessment

◻ Birth control pills
◻ Patch
◻ Tubal/Vasectomy
◻ Calendar/rhythm
◻ Abstinence
◻ DepoProvera
◻ IUD
◻ Condom
◻ Natural Family Planning
◻ Nuva Ring
◻ Diaphragm
◻ Foam
◻ Norplant
◻ Other

1st Follow Up:

◻ Birth control pills
◻ Patch
◻ Tubal/Vasectomy
◻ Calendar/rhythm
◻ Abstinence
◻ DepoProvera
◻ IUD
◻ Condom
◻ Natural Family Planning
◻ Nuva Ring
◻ Diaphragm
◻ Foam
◻ Norplant
◻ Other

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

42. (continued)

2nd Follow Up:

		☐ IUD	☐ Diaphragm
☐ Birth control pills	☐ Calendar/rhythm	☐ Condom	☐ Foam
☐ Patch	☐ Abstinence	☐ Natural Family Planning	☐ Norplant
☐ Tubal/Vasectomy	☐ DepoProvera	☐ Nuva Ring	☐ Other

43. Is there any reason why you feel that you are not ready to have a baby? ______________________

____

44. What types of questions or concerns do you have about preparing for your next pregnancy?

____

____

45. Do you practice safe sex? ☐Yes ☐ No

If yes, what methods do you use? ______________________

46. 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):

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

47. Is there any other reason you think you might be at risk for HIV/AIDS? ☐Yes ☐ No

If Yes, please explain: ______________________

____

48. Change in HIV/AIDS risk status? **1st Follow Up:** ☐ No ☐Yes, what? ______________________

2nd Follow Up: ☐ No ☐Yes, what? ______________________

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

Initial:	☐Yes	☐ No (Refer to medical provider)
1st Follow Up:	☐Yes	☐ No (Refer to medical provider)
2nd Follow Up:	☐Yes	☐ No (Refer to medical provider)

If Yes, do you have any questions? ______________________

____

Pt. Name: ______________________

Date of Birth: ______________________

Health Plan: ______________________

Identification No: ______________________

Current Health Practices and Status

50. Do you currently have a doctor? □Yes □ No

51. How often do you follow the recommendations from your doctor or healthcare provider?
□ Always □ Most of the time □ Sometimes □ Rarely □ Never

52.Have you been to the doctor or a clinic for an annual check up during the past 12 months? □Yes □ No

53. Have you had a pap smear test and a clinical breast exam during the past 12 months? □Yes □ No
If no, why not? ________________
If yes, would you like to tell me if there were any problems with the results? □Yes □ No
please describe: ________________

54. Do you have any gynecologic symptoms that you are concerned about? (such as vaginal bleeding, discharge w/an unpleasant odor and/or itching, burning, and swelling in the vaginal area) □Yes □ No

Have you seen a doctor about this problem? □Yes □ No

55. Do you have any of these medical risk factors that relate to having a healthy pregnancy? (Check all that apply.)
□ ≤ 19 years old □ ≥ 35 years old □ Type 1 diabetes □ Type 2 diabetes
□ hx of gestational diabetes □ hx of pregnancy related hypertension □ hypertension
□ other: ________________

56. If you have been told you have diabetes, did you eat before you took your test for diabetes? □Yes □ No

57. Do your children have a doctor? □Yes □ No

58. Do you know how to find a doctor for you and your family? □Yes □ No, explain: ________________

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

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

61. When was the last time you went to the dentist? ________________

62. Have you had any dental problems in the past 6 months or year? □Yes □ No
If yes, please describe: ________________
Did you get treatment for these problems? □ Yes □ No
If yes, what treatment did you get? ________________
If no, why didn't you get treatment? ________________

63.When was the last time you received immunizations or shots? ________________
May I see your shot record? □Yes □ No
If yes, check record for evidence of varicella, tetanus, hepatitis B, and MMR vaccination.
If no, Have you had the chickenpox or a chickenpox shot? ________________

Did you receive all of the MMR shots recommended? ________________

Have you received all the Hepatitis B shots recommended? ________________

When was the last time you got a tetanus shot? ________________

64. When was the last time you were tested for tuberculosis? ________________

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

65. Have you had frequent bladder infections or any problems with your kidneys? □Yes □ No

66. Have you ever had any trouble getting pregnant (tried for over 1 year)? □Yes □ No

67. Has your doctor ever told you that you have a disease or condition that you may need to receive treatment for over a long period of time? (such as diabetes, high blood pressure, asthma)? □Yes □ No
If yes, what is the disease or condition(s)? ______________________________

68. Are you receiving treatment for the disease or condition? □Yes □ No
If no, why not? ______________________________

69. Do you need help finding a doctor, support group, or educational program to help you deal with the condition?
□ Yes □ No

70. Do you have any health problems that you are concerned about? □Yes □ No
If yes, what is the health problem that you are concerned about? ______________________________

71. On average, how many total hours a night do you sleep?
Initial: ____________ **1st Follow Up:** ____________ **2nd Follow Up:** ____________

72. On average, how many hours do you nap a day?
Initial: ____________ **1st Follow Up:** ____________ **2nd Follow Up:** ____________

73. What do you do for exercise? ____________ How often? ____________

74. Do you have exposure to chemicals:

	Initial:		**1st Follow Up**		**2nd Follow Up**		
	Yes	No	Yes	No	Yes	No	
a. At work?	□	□	□	□	□	□	If yes, what? ____________
b. At home?	□	□	□	□	□	□	If yes, what? ____________
c. With hobbies?	□	□	□	□	□	□	If yes, what? ____________

75. Do you smoke cigarettes?
Initial: □Yes □ No How many per day? ____________ For how many years? ____________
1st Follow Up : □Yes □ No How many per day? ____________ For how many years? ____________
2nd Follow Up: □Yes □ No How many per day? ____________ For how many years? ____________

	Initial		1st Follow Up		2nd Follow Up	
	Yes	No	Yes	No	Yes	No
76. Are you exposed to secondhand smoke at home or at work?	□	□	□	□	□	□
77. Are you using chewing tobacco?	□	□	□	□	□	□

78. 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

79. How often do you drink alcohol (beer, wine, wine coolers, hard liquor, mixed drinks)?
□ Daily □ Weekends □ 1-2 times per month □ Rarely or never

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

80. In your home, how do you store:
☐ Vitamins ____________________ ☐ Medications ________________ ☐ Cleaning Agents: ________________________

81. Within the last 6 months, have you used any prescription medications?
For example prenatal vitamins, iron, allergy medication, Aldomet ®, Prozac ®, other? ______________________________

Initial: ☐ None ☐ Yes: ____
1st Follow Up: ☐ None ☐ Yes: ____
2nd Follow Up: ☐ None ☐ Yes: ____

82. Within the last 6 months, have you used any over-the-counter medications?
For example Tylenol ®, Tums ®, Sudafed ®, laxatives, appetite suppressants, aspirin, other?

Initial: ☐ None ☐ Yes: ____
1st Follow Up: ☐ None ☐ Yes: ____
2nd Follow Up: ☐ None ☐ Yes: ____

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

Initial: ☐ None ☐ Yes: ____
1st Follow Up: ☐ None ☐ Yes: ____
2nd Follow Up: ☐ None ☐ Yes: ____

84. Within the last 6 months, have you used street drugs (marijuana, cocaine, PCP, crack, speed, crank, ice, heroin, LSD, other)?

Initial: ☐ None ☐ Yes: If yes, what? ________________________ How often? ____________________
1st Follow Up: ☐ None ☐ Yes: If yes, what? ________________________ How often? ____________________
2nd Follow Up: ☐ None ☐ Yes: If yes, what? ________________________ How often? ____________________

85. If you use drugs, are you interested in quitting? ☐Yes ☐ No

86. Have you tried to quit? ☐Yes ☐ No
comments: ____
____
____

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

Educational Interests

87. 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? (Column B) Both columns may be marked:

Topic	Initial		1st Follow Up		2nd Follow Up		Educational Materials Provided		
	A	B	A	B	A	B	Date	Code*	Initials
Assistance with cutting down/quitting smoking	☐	☐	☐	☐	☐	☐			
Healthy habits for a healthy pregnancy/baby	☐	☐	☐	☐	☐	☐			
How to avoid sexually transmitted infections/HIV	☐	☐	☐	☐	☐	☐			
How to take care of your baby/infant safety	☐	☐	☐	☐	☐	☐			
Breastfeeding	☐	☐	☐	☐	☐	☐			
Diabetes	☐	☐	☐	☐	☐	☐			
Hypertension	☐	☐	☐	☐	☐	☐			

Teaching Codes: **A**= Answered questions **E**=Explained verbally **V**=Video shown
W=Written material provided **S**=Visual aids shown **I**=Interpreter

88. Is there anything special you would like to learn about? ______________________
.____

89. 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: ____

90. Will someone be able to attend classes with you? ☐ Yes ☐ No Who? ______________________

91. 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 and Diet

92. Height without shoes (feet/inches): ______________________

93. What is your current weight? ______________________

94. Did your doctor tell you to take any vitamins or supplements? ☐Yes ☐ No
If yes, which vitamins/supplements? ______________________

95. Do you take a multivitamin/mineral supplement that includes folic acid? ☐Yes ☐ No
If yes, which one? ______________________
How often do you take it? ______________________

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

96. Do you take iron every day? ☐Yes ☐ No
If no, why not?
Which other vitamins/supplements do you take? ______
How often? ______

97. Has a doctor told you that you have anemia in the last year? ☐Yes ☐ No

98. How many meals do you eat per day? ______

99. Are there any foods that you are avoiding? ☐Yes ☐ No
If yes, what foods? ______
Are you able to tolerate (digest) milk or dairy products? ☐Yes ☐ No
Do you ever skip meals? ☐Yes ☐ No
If yes, why? ______

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

______

101. Do you ever eat raw fish (such as shrimp, oysters, clams, mussels, others), meat (such as beef, lamb, or poultry) or undercooked meat and poultry? ☐Yes ☐ No

102. 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: ______

1st Follow Up: Has this changed? ☐ No ☐Yes, how? ______
2nd Follow Up: Has this changed? ☐ No ☐Yes, how? ______

103. Who usually does the following in your home? Buys food: ______ Prepares food: ______

104. If you have children, did you breastfeed, or try to breastfeed them? ☐ Yes ☐ No
Did you have trouble breastfeeding? ☐ Yes ☐ No How long did you breastfeed? ______

Coping Skills

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

	Initial	**1st Follow Up**	**2nd Follow Up**
None	☐	☐	☐
Housing	☐	☐	☐
Financial difficulties	☐	☐	☐
Divorce/Separation	☐	☐	☐
Recent death	☐	☐	☐
Illness (TB, cancer, abn. pap smear)	☐	☐	☐
Unemployment	☐	☐	☐
Immigration	☐	☐	☐
Legal	☐	☐	☐
Probation/parole	☐	☐	☐
Child Protective Services	☐	☐	☐

Other: ______ Other: ______ Other: ______

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

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

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

108. Do you feel anxious or stressed at home, work, and/or school? ☐ Yes ☐ No

109. What do you do to relax? ______________________________

110. Is there someone you can talk to about your problems or when you're feeling anxious and/or stressed?
☐ Yes ☐ No If yes, who? ______________________________

111. What things in your life do you feel good about?
Initial: ______________________________

1st Follow Up: ______________________________

2nd Follow Up: ______________________________

112. What things in your life would you like to change?
Initial: ______________________________

1st Follow Up: ______________________________

2nd Follow Up: ______________________________

113. Are you happy with your current weight? ☐ Yes If No, please explain: ______________________________

114. What do you do when you are upset? ______________________________

115. 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

116. Do you ever get depressed? ☐ Yes ☐ No

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

118. Is there anyone you can turn to for help and encouragement? (examples: parents, siblings, friends, boyfriend, etc.)
☐ No ☐ Yes If yes, who? ______________________________

119. 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

120. What do you or your partner do when you have disagreements? ______________________________

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

121. 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: ____________________

122. Do you ever feel afraid or threatened by your partner? ☐ Yes ☐ No
If yes, please explain: ____________________

123. 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: ____________________

124. Within the last year has anyone forced you to have sexual activities?
Initial: ☐ No ☐ Yes If yes, who? ☐ Husband ☐ Ex-husband ☐ Boyfriend
☐ Partner ☐ Stranger ☐ Multiple ☐ Other: ____________________
Total number of times: ____________________
Please explain: ____________________

1st Follow Up: ☐ No ☐ Yes If yes, who? ☐ Husband ☐ Ex-husband ☐ Boyfriend
☐ Partner ☐ Stranger ☐ Multiple ☐ Other: ____________________
Total number of times: ____________________
Please explain: ____________________

2nd Follow Up: ☐ No ☐ Yes If yes, who? ☐ Husband ☐ Ex-husband ☐ Boyfriend
☐ Partner ☐ Stranger ☐ Multiple ☐ Other: ____________________
Total number of times: ____________________
Please explain: ____________________

125. Are your children, or have your children been victims of violence or sexual abuse? ☐ Yes ☐ No
If Yes, please explain: ____________________

126. Have you ever talked to a counselor? ☐ Yes ☐ No
If Yes, please explain: ____________________

127. Would you feel comfortable talking to a counselor if you had a problem? ☐Yes ☐ No
If No, why? ____________________

Please note: Highlighted text is optional.

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

Initial Assessment Completed by:

Name and Title	Initials	Date	Minutes

Second Trimester Reassessment Completed by:

Name and Title	Initials	Date	Minutes

Third Trimester Reassessment Completed by:

Name and Title	Initials	Date	Minutes

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