Prenatal Plus Program

Initial Assessment Form

Name_____ Date of Birth _____ Medicaid # _____

Please answer the questions in the left column honestly so we can help you while you are pregnant.
The Prenatal Plus care coordinator will complete the shaded section in the right column.

Pregnancy History

1. Have you been pregnant before? ❑ Yes ❑ No
   (If no, skip to #7. If yes, please answer the following.)

2. How many children do you have? _____

3. How many times have you been pregnant, including this pregnancy?
   _____

4. Have you ever had a miscarriage? ❑ Yes ❑ No
   If yes, how many have you had?_____
   How far along were you with each one?_____

5. With any past pregnancy, did you have any of the following:
   - ❑ baby born 3 or more weeks early (less than 37 weeks)
   - ❑ premature labor
   - ❑ infant birth weight 5 lb. 8oz. or less
   - ❑ preeclampsia, toxemia, or pregnancy-related high blood pressure
   - ❑ bed rest for any part of the pregnancy
   - ❑ baby born with birth defects
   - ❑ pregnancy-related diabetes (problems with blood sugar)
   - ❑ fetal or infant death (a baby that died during pregnancy or after birth)
   - ❑ depression during or after the pregnancy

6. Have you ever breast fed a baby? ❑ Yes ❑ No
   If yes, for how long? _____
   Why did you stop? _____
   Did you have any problems? ❑ Yes ❑ No

7. Have you ever thought about breastfeeding the new baby?
   ❑ Yes ❑ No

8. Are you having twins or triplets? ❑ Yes ❑ No

9. Were you using birth control when you got pregnant?
   ❑ Yes ❑ No If yes, what type?_____

10. Are you going to a health care provider for prenatal care?
    ❑ Yes ❑ No If yes, who? _____

To Be Completed By Care Coordinator

G_____ P_____ AB _____ LC_____
LMP_____ EDD _____

G	# of pregnancies including this one
P	# of deliveries
AB	# of abortions or miscarriages
LC	# of living children
LMP	Last menstrual period
EDD	Estimated date of delivery

Weeks Gestation at enrollment _____

Client's age at time of delivery _____

Clarify responses here:
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Date of first prenatal care visit _____

Date of next prenatal care visit _____

Medical History

1. Do you have a family doctor? ❑ Yes ❑ No
   If yes, who? _____

2. Do you have a dentist? ❑ Yes ❑ No
   Have you had a dental exam in the last year? ❑ Yes ❑ No

3. Have you had an eye exam in the last year? ❑ Yes ❑ No

4. Do the children in your family have a doctor? ❑ Yes ❑ No
   If yes, who? _____

5. Have your children had all of their shots and check-ups? ❑ Yes ❑ No

6. Are you currently in a program where nurses visit you in your home during pregnancy? ❑ Yes ❑ No
   If yes, who visits? _____

7. Please check if you have ever been told you had:
   - ❑ diabetes
   - ❑ high blood pressure
   - ❑ hepatitis/liver problems
   - ❑ positive HIV test or AIDS

8. Since your last menstrual period, have you taken any of the following?

   - ❑ Accutane (medicine for acne)
   - ❑ birth control pills
   - ❑ antibiotics
   - ❑ cold tablets
   - ❑ hay fever pills
   - ❑ pain medication
   - ❑ Aspirin
   - ❑ Tylenol
   - ❑ sleeping pills
   - ❑ prenatal vitamins
   - ❑ iron pills
   - ❑ other vitamins/minerals/herbs
   - ❑ laxatives
   - ❑ diet pills
   - ❑ other medications (please list)

   _____
   _____

Nutrition and Exercise

1. During this pregnancy have you had any nausea or vomiting?
   ❑ Yes ❑ No

2. Do you have any problems that make eating difficult?
   ❑ Yes ❑ No If yes, what? _____

3. How many times do you eat each day? _____

4. Are you on a special diet now such as: low-calorie, low-salt, low-carb, diabetic? ❑ Yes ❑ No
   If yes, why?_____

Clarify responses here:

Do a 24-hour recall if more diet information is needed or there are concerns.

5. Do you eat or crave non-food items like clay, laundry starch, paint chips, paper, dirt, or ice? ☐ Yes ☐ No
If yes, what, how much, and how often?
____

6. How tall are you? ____________
How much did you weigh just before this pregnancy? __________

7. If you have been pregnant before, how much weight did you gain with each pregnancy? ____________________________

8. How much weight do you expect to gain during this pregnancy?
____

9. Do you exercise? ☐ Yes ☐ No
If yes, what do you do for exercise and how often?
____

10. Have you ever run out of food? ☐ Yes ☐ No

11. Do you feel you have enough food now? ☐ Yes ☐ No

12. Have you tried any of the following to lose weight?
- ☐ used laxatives
- ☐ made yourself vomit
- ☐ taken water pills (diuretics)
- ☐ taken diet pills
- ☐ not eaten regularly or skipped meals
- ☐ over exercised
- ☐ none of the above

13. Have you ever felt you have lost control over how much you eat?
☐ Yes ☐ No

14. Have you ever thought or been told you had anorexia or bulimia?
☐ Yes ☐ No

Sources of Income

1. Is the father of the baby involved? ☐ Yes ☐ No
Is he planning to help financially with the baby? ☐ Yes ☐ No

2. Are you and your partner working now?
You ☐ Yes ☐ No Partner ☐ Yes ☐ No
If you work, what is your job? __________________________________
If your partner works, what is his job? ____________________________

3. Check if you receive:
- ☐ Medicaid
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ WIC
- ☐ Food Stamps
- ☐ Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- ☐ Other income/resources ____________________________

4. Do you want information about any of the above programs?
☐ Yes ☐ No

Client's BMI Status and wt. gain recommendations

Client's BMI: __________________
- ☐ Low (<19.8) 28-40 # gain
- ☐ Normal (19.8-26.0) 25-35 # gain
- ☐ High (26.1-29.0) 15-25 # gain
- ☐ Obese (>29.0) 15 # gain

Start weight gain grid. Refer to RD if weight gain below appropriate line or weight loss.

Is client's weight gain expectation appropriate? ☐ Yes ☐ No

Education provided on weight gain:
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Clarify responses here:
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Next WIC appointment:
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Medicaid Technician:
____
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Education/Vocation Goals

1. Are you currently in school? ❑ Yes ❑ No
   If yes, what grade?_____

2. Did you graduate from high school or get a GED? ❑ Yes ❑ No
   If no, what grade did you last finish? _____
   Are you interested in finishing? ❑ Yes ❑ No

3. Do you have a learning disability? ❑ Yes ❑ No

4. Do you plan to work or go to school after the baby is born?
   ❑ Yes ❑ No If yes, how soon? _____

Living Arrangements

1. What type of transportation do you use?_____

2. Do you need information on how to use the bus system/public transportation? ❑ Yes ❑ No

3. Where do you live?
   - ❑ apartment, house, mobile home
   - ❑ shelter
   - ❑ no housing
   - ❑ other_____

4. How many times have you moved in the last 12 months? _____

5. Check if your home does NOT have:
   - ❑ a way to cook food
   - ❑ telephone or cell phone
   - ❑ refrigerator
   - ❑ heating system
   - ❑ hot water
   - ❑ toilet
   - ❑ bath and/or shower

6. Do you think your current housing situation is adequate and safe?
   ❑ Yes ❑ No

7. People living with you in your home:

Name	Relationship to you	Age

8. Do you have other children who do not live with you? ❑ Yes ❑ No
   If yes, where do they live?_____

Client education and vocational goals:

Clarify responses here:

Psychosocial

1. When you first learned you were pregnant, how did you feel about it? (Check the best answer)
   - ❑ I wanted to be pregnant sooner
   - ❑ I wanted to be pregnant then
   - ❑ I wanted to be pregnant later
   - ❑ I did not want to be pregnant then or at any time in the future

2. How does the baby's father feel about the pregnancy?

3. Describe your parents while you were growing up.

4. What does it mean to be a good mom?

5. What causes you to feel stressed?

6. When you are upset, do you (check all that apply):
   - ❑ cry
   - ❑ count your blessings, hope, pray, think "I can make it"
   - ❑ talk to someone
   - ❑ rock
   - ❑ ignore it
   - ❑ try to keep busy (watch TV, listen to music, read, shop)
   - ❑ practice relaxing
   - ❑ use drugs
   - ❑ drink alcohol
   - ❑ eat
   - ❑ try to figure out what's going on
   - ❑ smoke
   - ❑ go for a walk
   - ❑ sleep
   - ❑ daydream
   - ❑ lose your temper
   - ❑ party
   - ❑ think of the future
   - ❑ take it out on someone else
   - ❑ other_____

7. List events which happened to you in the past year that were good or bad (job, move, school, pregnancy, marriage, divorce, etc.)

   Good Events Bad Events

Clarify responses here:

8. What do you feel is the best thing about yourself? What are your strengths? What would people who know you say they like about you?

9. Who in your life is the most helpful and supportive to you?

_____

10. Is there someone who gives you advice about your pregnancy?
❑ Yes ❑ No If yes, who? _____

11. Who do you wish would be more helpful or supportive to you?

_____

12. Have you ever had or felt any of the following (check all that apply):
- ❑ Depression
- ❑ Anxiety
- ❑ Postpartum depression or the "baby blues"
- ❑ Bi-polar disorder
- ❑ Schizophrenia
- ❑ Other_____

Did you see a counselor for any of the above?
❑ Yes ❑ No If so, when? _____
For how long? _____

Did you take medicine for any of the above?
❑ Yes ❑ No If yes, what kind? _____
When did you last take it? _____
Who prescribed it? _____

Were you hospitalized for any of the above?
❑ Yes ❑ No If so, when? _____
For how long? _____

13. Over the past month, how often have you been bothered by any of the following problems?

	Not at all	Some of the time	Most of the time	All of the time
Little interest in doing things	❑	❑	❑	❑
Feeling down, depressed or hopeless	❑	❑	❑	❑
Had trouble sleeping	❑	❑	❑	❑

14. Do you have concerns about postpartum depression or the "baby blues"?
❑ Yes ❑ No

15. Do you have any thoughts or plans about hurting yourself?
❑ Yes ❑ No

16. In the past, have you ever tried to hurt yourself?
❑ Yes ❑ No
If yes, how and when? _____

17. Do you have any thoughts or plans about hurting anyone else?
❑ Yes ❑ No

Clarify responses here:

18. Have you ever repeatedly been put down, or hurt emotionally?
❑ Yes ❑ No If yes, when? _____

19. Are you now, or have you ever been hit, slapped, kicked, pushed, or otherwise physically hurt?
❑ Yes ❑ No If yes, when?_____

20. Are you now, or have you ever been uncomfortably touched or forced into sexual contact?
❑ Yes ❑ No If yes, when? _____

21. Does anyone in your life make you feel humiliated, threatened or afraid?
❑ Yes ❑ No If yes, who? _____

22. How safe do you feel in your current living situation?
❑ very safe
❑ somewhat safe
❑ very unsafe
❑ not really sure how safe

23. Have you ever been involved with the legal system (juvenile court, probation, jail, parole)? ❑ Yes ❑ No
If yes, when? _____

24. Have you ever been accused of child abuse or neglect?
❑ Yes ❑ No If yes, when? _____

25. Have you ever been in the foster care system?
❑ Yes ❑ No If yes, when? _____

Lifestyle
Please answer these questions honestly so we can help you receive the best possible care for you and your baby.

	Before Pregnancy	**Since getting Pregnant**
1. Smoke cigarettes?	❑Yes ❑ No	❑Yes ❑ No
2. How many cigarettes do you smoke in a day?	_____	_____
3. Use chewing tobacco?	❑Yes ❑ No	❑Yes ❑ No

4. Does your partner or anyone else in your home smoke, or are you around people who are smoking? ❑ Yes ❑ No

5. If you are currently smoking, or have recently used tobacco, please check the best answer below:
❑ I do not want to quit
❑ I have thought about quitting, but I'm not ready yet
❑ I want to quit soon
❑ I quit smoking recently
❑ I quit smoking and I am sure I won't start again
❑ I quit, but I've started smoking again

6. Would you like help to quit smoking while you are pregnant?
❑ Yes ❑ No

Clarify responses here:

** For the following questions a drink equals one 12 ounce bottle or can of beer, one 4 ounce glass of wine, or one shot (one ounce) of hard liquor

7. When was your last drink?
   - ❑ this week
   - ❑ last week
   - ❑ last month
   - ❑ _____months ago
   - ❑ never

8. How many drinks does it take you to first feel the effects of alcohol?
   _____ (number of drinks)

9. Have you ever been treated for problems with alcohol?
   ❑ Yes ❑ No If yes, when?_____

10. Would you like help to quit drinking alcohol while you are pregnant?
    ❑ Yes ❑ No

11. When was the last time you used drugs?
    - ❑ this week
    - ❑ last week
    - ❑ last month
    - ❑ _____months ago
    - ❑ never

	Before Pregnancy	**Since getting Pregnant**
12. Sniff gasoline, glue, or other substance to get high?	❑Yes ❑ No	❑Yes ❑ No
13. Use street drugs:		
• marijuana	❑Yes ❑ No	❑Yes ❑ No
• meth/speed	❑Yes ❑ No	❑Yes ❑ No
• cocaine/crack	❑Yes ❑ No	❑Yes ❑ No
• heroin	❑Yes ❑ No	❑Yes ❑ No
• ecstasy	❑Yes ❑ No	❑Yes ❑ No
• PCP or LSD	❑Yes ❑ No	❑Yes ❑ No
• Use needles for drugs	❑Yes ❑ No	❑Yes ❑ No
• other _____	❑Yes ❑ No	❑Yes ❑ No

14. Have you ever been addicted to painkillers such as Percocet, Vicodin or Oxycontin? ❑Yes ❑ No

15. Have you ever been treated for problems with drugs?
    ❑ Yes ❑ No If yes, when?_____

16. Would you like help to quit using drugs while you are pregnant?
    ❑ Yes ❑ No

17. Does your partner or anyone else in your home have problems with alcohol or drugs? ❑ Yes ❑ No

Clarify responses here:

Education and Resources

The Prenatal Plus Program can help you and give you information for your pregnancy. Please check any topics you are interested in:

- ❑ breastfeeding and other infant feeding options
- ❑ finding a doctor for yourself or your family
- ❑ nutrition
- ❑ exercise
- ❑ assistance getting food
- ❑ work options
- ❑ resources for clothing, furniture, baby items, etc.
- ❑ financial help
- ❑ school
- ❑ housing or shelters
- ❑ counseling
- ❑ getting along with your partner or family members
- ❑ postpartum depression or anxiety
- ❑ quitting smoking
- ❑ secondhand smoke
- ❑ quitting drugs or alcohol
- ❑ coping with changes in pregnancy
- ❑ growth and development of your baby
- ❑ how to prevent a low birthweight or premature baby
- ❑ parenting
- ❑ childbirth classes
- ❑ labor and delivery
- ❑ caring for yourself and your baby after you get home
- ❑ birth control methods
- ❑ day care
- ❑ other_____

Clarify responses here:

Client Signature: _____ **Date Completed:** _____

Care Coordinator Signature:_____ **Date Reviewed:** _____

Assessment Summary: