BREASTFEEDING/NOT BREASTFEEDING INTERVIEW

Name/Participant ID:

Assessed by:

Date:

BREASTFEEDING SUPPORT

1/2a. How is it being a new mom?

Listen, ask, and assess for

- *Postpartum depression*
- *Struggles*
- *Successes*
- *Caregiver ability*

☐ 361 Clinical Depression
☐ 902 Primary caregiver with limited ability to make feeding decisions

1b. How is breastfeeding going for you?

Listen, ask, and assess for

- *Successes*
- *Challenges*
- *Milk supply*
- *Teething/biting*
- *Baby preferring one breast*
- *Baby not interested*
- *Soreness/nipple care*
- *Breast leaking*

☐ 602/ – Breastfeeding Complications
☐ 602a Severe Engorgement
☐ 602b Recurrent plugged ducts
☐ 602c Mastitis
☐ 602d Flat or inverted nipples
☐ 602e Cracked, bleeding or severely sore nipples
☐ 602g Failure of milk to come in by 4 days postpartum
☐ 602h Tandem nursing (BF two siblings who are not twins)

1c. How long are you planning to breastfeed your infant?

Listen, ask, and assess for

- *Returning to work or school*
- *Pumping*
- *Storage*
- *Continuation of Breastfeeding*
- *Anticipated or current separation from infant*

1d. Are you currently employed or attending school >10 hours/week? ☐ Yes ☐ No

1e. What type of support do you have for breastfeeding?

Listen, ask, and assess for

- *Partner/spouse*
- *Other family members*
- *Friends/peers*
- *Work/school environment*

1f. Do you need any help or assistance from the WIC Program?

Listen, ask, and assess for

- *Breastfeeding equipment need, current use, type, experience*
- *Lactation specialist*
- *Additional referral*

1g. We have moms who have breastfed and can help you with breastfeeding. I will have one call you. *Ask only if a Peer Counselor is available in your agency.*

Interested in the Breastfeeding Peer Counselor Program ☐ Yes ☐ No

HEALTH/MEDICAL

2b. What concerns do you or your doctor have about your health?

Listen, ask, and assess for

- *Medical conditions*
- *Family planning*

***2c. Any medical conditions, illnesses, or special needs?** ☐ Yes ☐ No

2d. Are you currently taking any medication? ☐ Yes ☐ No

***2e. Was this your first pregnancy?** ☐ Yes ☐ No

____*Number of previous pregnancies
____*Number of live births
____Number of pregnancies past 20 weeks/5 months
____*Number of babies this pregnancy

2f. Did you have any complications or special conditions with this pregnancy?

☐ 303 – Hx of gestational diabetes
☐ 311 – Hx of preterm delivery
☐ 312– Hx of Low Birth Weight infant
☐ 321b– (BF) Multifetal gestation with one or more fetal or neonatal deaths but with one or more infants still living
☐ 321c – (N) Spontaneous abortion, fetal or neonatal loss
☐ 325 – Multifetal gestation

☐ 339 – Hx of congenital birth defects

☐ 304 – Hx of Preeclampsia

2g. Do you ever have a hard time chewing or eating certain foods?
Listen, ask, and assess for

- *Oral health care/Referral*
- *Tooth decay*
- *Tooth loss*
- *Impaired ability to eat*
- *Gingivitis*

☐ 381/HY– Dental Problems

NUTRITION PRACTICES

3a. Tell me what you like to eat and drink.
Listen, ask, and assess for

- *Drink to thirst*
- *Appetite*
- *Timing of meals*
- *Meals, snack, and drinks*
- *Eating pattern*
- *Frequency*
- *Eating problems*
- *Food preparation*
- *Food likes and dislikes*
- *Folic acid rich foods*
- *Pica*

3b. What would you like to change about your eating?

3c. Is there anything you would like to eat more or less of?

3d. Do you take any vitamins, minerals, herbs, or dietary supplements?

Nutrition Practices:

☐ 427a – consuming supplements with harmful consequences
☐ 427b – consuming diet low in calories
☐ 427c – compulsively ingesting non-food items (pica)
☐ 427d – inadequate vitamin/mineral supplementation
☐ 425e – Ingesting potentially harmful foods (Food Safety)
☐ 353 – Food allergy: wheat, corn, soy, peanuts, eggs, milk,entire food group
☐ 401 – Failure to meet Dietary Guidelines for Americans (>=24 m of age)

3e. Do you have any problems with food preparation and/or storage?
Listen, ask, and assess for

- *Refrigeration*
- *Cooking equipment*
- *Family table*
- *Safe water*

LIFE STYLE

***4a. In the 3 months before you were pregnant, how many cigarettes did you smoke on an average day?** ____Cigarettes/day

***4b. In the last 3 months of your pregnancy, how many cigarettes did you smoke on an average day?** ____Cigarettes/day

***4c. How many cigarettes do you smoke on an average day now?** ____Cigarettes/day

***4d. Does anyone living in your household smoke inside the home?** ☐ **Yes** ☐ **No**

***4e. In the 3 months before you were pregnant, how many alcoholic drinks did you have in an average week?** ____Drinks/week

***4f. In the last 3 months of your pregnancy, how many alcoholic drinks did you have in an average week?** ___Drinks/week

4g. Do you currently drink alcohol? ☐ Yes ☐ No **If yes, how much and how often?**

___Drinks/week 372 *Routine or current use of ≥ 2 or more drinks/day or binge drinking on one day in the past 30 days*

4g. In the three months before you were pregnant, did you use street drugs? How about now? Yes ☐ 372 Illegal Drug Use

4h. What are your plans for returning to your pre-pregnancy shape
Listen, ask, and assess for

- *Physical activities*
- *Walking*
- *Playing with children*
- *Safe parks*
- *Access to fitness centers*
- *Activity frequency*
- *Food consumption changes*

SOCIAL ENVIRONMENT

5a. What else can I help you with?
Listen, ask, and assess for

- *Abuse/neglect in the last 6 months*
- *Limited ability to make appropriate feeding decision or prepare foods*
- *Family planning*