1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYYY)	Month / Day / Year	
4. Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ Unknown ☐ White		
5. Ethnic Origin ☐ Hispanic Cuban ☐ Hispanic Mexican American ☐ Hispanic Other ☐ Hispanic Puerto Rican ☐ Not Hispanic/Latino ☐ Unreported		
6. Gender ☐ Female ☐ Male		
7. County of Residence		

N.C. Department of Health and Human Services
Division of Public Health
Women's and Children's Health Section

MATERNAL HEALTH HISTORY — PART C-1
Initial Psychosocial Screening

(TO BE SELF-ADMINISTERED OR COMPLETED BY STAFF)

Please complete the following questions.
Put an X or check mark in the box for YES or NO, as it applies. When completed, sign and date the form and return to staff.*

QUESTION	YES	NO
1. Do you have a safe place to live?		
2. Do you have working appliances (such as stove, refrigerator, indoor plumbing, etc.)?		
3. Do you have any physical limitations or any problems hearing, reading, speaking, or understanding?		
4. Have you experienced any type of significant loss in the last year such as death, loss of job, housing, relationship breakup, major illness or a loved one in the military being deployed?		
5. Do you have any problems that will keep you from your clinic appointments such as no transportation, conflict with your working hours, lack of childcare or lack of support?		
6. Over the past two weeks have you felt down, depressed, or hopeless?		
7. Over the past two weeks have you felt little interest or pleasure in doing things?		
8. Over the past two weeks have you thought about hurting yourself or someone else?		
9. Within the past year have you been threatened or actually hit, slapped, kicked, or otherwise physically hurt by anyone?		
10. Since you have been pregnant, have you been threatened or actually hit, slapped, kicked, or otherwise physically hurt by anyone?		
11. Within the last year, has anyone forced you to have sexual activities which made you feel uncomfortable?		
12. Do you smoke or chew tobacco or dip snuff?		
13. Do others smoke around you?		

14. If you could pick the best timing for your pregnancy would you like to be pregnant
☐ At another time ☐ Would not change it, my pregnancy was planned
☐ Not at all ☐ Would not change it, even though it was not planned

15. Check off any of the following that you are using now or used in the past year
Now: ☐ Alcohol ☐ Marijuana ☐ Cocaine/Crack Cocaine ☐ Heroin ☐ IV Drugs ☐ Prescription Drugs ☐ None ☐ Other_____________
Past: ☐ Alcohol ☐ Marijuana ☐ Cocaine/Crack Cocaine ☐ Heroin ☐ IV Drugs ☐ Prescription Drugs ☐ None ☐ Other_____________

16. Check off any of the following that your partner is using now or used in the past year
Now: ☐ Alcohol ☐ Marijuana ☐ Cocaine/Crack Cocaine ☐ Heroin ☐ IV Drugs ☐ Prescription Drugs ☐ None ☐ Other_____________
Past: ☐ Alcohol ☐ Marijuana ☐ Cocaine/Crack Cocaine ☐ Heroin ☐ IV Drugs ☐ Prescription Drugs ☐ None ☐ Other_____________

Patient Signature (if self administered) ______________________________ **Date**_______________

Interpreter Used ☐ **N/A** ☐ No ☐ Yes **Interpreter Name** ______________________________

Staff Reviewer's Signature ______________________________ **Date** _______________

* NOTE: STAFF - PLACE RESULTS ON PART C-2

MATERNAL HEALTH HISTORY — PART C-1
Initial Psychosocial Screening
Instructions

Purpose: To assess and document initial psychosocial information on the prenatal patient.

Instructions: Instruct patient or staff to complete items 1-16. Staff should document results on the Interval Psychosocial screening form, Maternal Health History Part C-2.

Review results:

Case Management: A **"no"** response to #1 or #2, could be a referral to MCC or community resources.

Barriers to communication: A **"yes"** response to #3 could be a referral to an Interpreter or other Community Resources.

Stressors, Losses and Support: A **"yes"** response to #4 or 5 could be a need for referral to MCC, LCSW, or community resources.

Depression: #6 or #7 answer **"yes"** response needs mental health referral or LCSW
8 answer **"yes"** means **immediate crisis intervention** according to policy of Health Department.

Domestic Violence: #9, #10, #11 answer **"yes,"** for any or all needs further counseling by clinician to establish whether the patient is currently safe, needs a safety plan, or referral to community resources/mental health. There should be a health department policy guiding intervention of this procedure.

Tobacco: #12 and #13 answer **"yes,"** requires further clinician response including the 5 A's and evaluation for smoking cessation.

Intendedness: #14 answer **"at another time"** or **"not at all"** response needs more discussion with the clinician and a possible referral to MCC or LCSW.

Substance Abuse: #15 and #16 answering any of the choices other than **"None,"** needs further clinician evaluation. A referral to substance abuse counseling may be warranted or resources for family substance abuse counseling.

Document of referral and follow up should be documented in the narrative notes.

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Archives and History.

Reorder: Additional forms may be ordered from:

DHHS
Women's and Children's Health Section
1929 Mail Service Center
Raleigh, NC 27699-1929
Courier: #56-20-11
Phone: (919) 707-5700
FAX: (919) 870-4827