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

Healthy Beginnings Pregnant Assessment

Participant Information

Last Name **First Name** **MI**

Date of Birth Month | Day | Year

Race

☐ Black/African American
☐ White/Caucasian
☐ Asian
☐ American Indian or Alaska Native
☐ Native Hawaiian/Other Pacific Islander
☐ Biracial
☐ Other _____
☐ Unknown

Ethnic Origin ☐ Hispanic ☐ Non-Hispanic ☐ Not Identified

County of Residence

Home Address: ☐ Address change on Contact and Update Log

Phone: ☐ Phone # change on Contact and Update Log

Home # _____

Cell # _____

Can participant receive text messages? ☐ Yes ☐ No _____ Part. Initials

Which is the best way to reach you? ☐ Home ☐ Cell

☐ Other (specify) _____

Emergency Contact:

Name _____

Relation to Participant _____

Phone Number _____

Interpreter Services:

Do you need interpreter services? ☐ Yes ☐ No

What language do you prefer to speak/read?

_____

Does participant have health insurance?

☐ Yes ☐ No

List Type of Insurance: _____

_____

_____

_____

Client ID#

Date Form Initiated: Month | Day | Year

Staff Initials:

Contact Type: ☐ Phone ☐ Home Visit ☐ Office

☐ Other _____

Is participant enrolled in another program?

☐ Yes *(please specify)* _____ ☐ No

Participants **CANNOT** be enrolled in Healthy Beginnings if they are also enrolled in any of the following programs: Adolescent Parenting Program, Baby Love Plus, Nurse Family Partnership, or other home visiting program. Make sure to triage participants into the appropriate program to avoid duplication of services.

Medical Home:

Do you have a Primary Care Provider? ☐ Yes ☐ No

Name of Primary Care Provider

_____

Are you receiving Prenatal Care?

☐ Yes ☐ No If yes, date began receiving: ___ ___ _____ MM DD YYYY

Name of Prenatal Provider

_____

Referral needed? ☐ Yes ☐ No

Do you have a pediatrician? ☐ Yes ☐ No

Referral needed? ☐ Yes ☐ No

What is participant's highest level of education completed?

☐ Some High School
☐ High School Diploma or GED
☐ Some College, no Degree
☐ Associate's Degree (2-year school)
☐ Bachelor's Degree
☐ Graduate Degree
☐ Other, please specify _____

Currently enrolled in school?

☐ Yes ☐ No If yes, ☐ Full-time ☐ Part-time

If in school, list school schedule _____

_____

☐ No, but plans to enroll within the next year

Comments:

Currently Employed?

☐ Yes ☐ No If yes, ☐ Full-time ☐ Part-time

Place of employment _____

_____

If employed, list work schedule _____

_____

Transportation:

Do you need assistance with transportation to get to medical/social service appointments? ☐ Yes ☐ No

Do you have a plan for getting to the hospital for labor and delivery? ☐ Yes ☐ No

Personal:

Is the father of your baby involved in your life? ☐ Yes ☐ No

Who else do you depend on for support (i.e., partner, family, friends, faith community)?

_____

_____

Does the participant have other children? ☐ Yes ☐ No

Are any other children living in the household? ☐ Yes ☐ No

List the names, gender and ages of all children in the household:

_____

_____

_____

Date of Last Menstrual Period:

___ ___ _____
MM DD YYYY

Baby's Due Date:

___ ___ _____
MM DD YYYY

Pre-pregnancy BMI:

Pre-pregnancy BMI _____

Height _____ Pre-pregnancy Weight _____
Feet and Inches Pounds

* Provide the recommended weight gain during pregnancy based on her pre-pregnancy BMI.

Pregnancy Intendedness:
(check one)

☐ Wanted to Be Pregnant Now or Sooner
☐ Wanted to be Pregnant Later
☐ Did Not Want to Be Pregnant Now or at Any Time in the Future
☐ Doesn't Know
☐ Declined Answering

Comments:

Breastfeeding:

Are you planning on breastfeeding your baby?

☐ Yes ☐ No ☐ Not Sure

* Breastfeeding is good for you and your baby. At least six months is best, but any amount is good for your baby. It can help protect your baby from illnesses; help your baby grow and develop; and breast milk is easier for your baby to digest.

Lifestyle

Multivitamin/Folic Acid Consumption:

1) During the month before you got pregnant with your new baby, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?
   a) I didn't
   b) 1 to 3 times a week
   c) 4 to 6 times a week
   d) Every day of the week

2) How often do you take a multivitamin now?

   _____ Days a Week

* During pregnancy it is recommended to take a prenatal vitamin with at least 600 micrograms of folic acid. Folic acid may help reduce your baby's risk for birth defects of the brain and spine (neural tube defects).

Tobacco Use/Smoking/Secondhand Smoke Exposure:

The 5A's Method of Counseling Women Who Smoke

1st A — **ASK**

State: "I ask all of my participants these questions because it is important to your health and the health of your baby."

1) "Which of the following statements best describes you?" *(Read each statement below and circle her response)*

a) I have NEVER smoked, or have smoked FEWER THAN 100 cigarettes in my lifetime.

b) I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now.

c) I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.

d) I smoke now, but I cut down on the number of cigarettes I smoke SINCE I found out I was pregnant.

e) I smoke regularly now, about the same as BEFORE I found out I was pregnant.

- For responses **"a"** — Congratulate her. **Go to question #3** on page 3.
- For responses **"b and c"** — Congratulate her success in quitting and reinforce her decision to stay quit. **Go to question #3** on page 3.
- For responses **"d and e"** — **Go to Question #2** and continue to the next step ADVISE (Educate) on page 3.

2) How many cigarettes do you smoke on an average day now?

a) Less than 1 cigarette

b) 1 to 5 cigarettes

c) 6 to 10 cigarettes

d) 11 to 20 cigarettes

e) 21 or more cigarettes

Name _____ Date of Birth _____

Tobacco Use/Smoking/Secondhand Smoke Exposure (continued):

The 5A's Method of Counseling Women Who Smoke (continued)

2nd A — **ADVISE (Educate)**

- Provide clear advice to quit
- Discuss health benefits of quitting for her and her baby
- Discuss health risks of tobacco use for her and her baby

3rd A — **ASSESS**

State: "Are you willing to quit using tobacco within the next 30 days?"

- **"Yes"** — Continue to ASSIST
- **"No"** — Provide motivational intervention — The 5R's
  - o **Relevance:** why quitting may be personally relevant to her
  - o **Risks:** why she thinks tobacco use is bad for her and her baby
  - o **Rewards:** how quitting may benefit her, her baby and family
  - o **Roadblocks:** ask her to identify barriers and solutions
  - o **Repetition:** Ask her at every visit if she is ready to quit

4th A — **ASSIST**

- Provide educational and self-help materials
- Set a quit date and develop a quit plan (make this an empowerment goal)
- Discuss triggers and coping strategies
- Develop problem solving techniques
- Provide support and help identify other sources of support
- Refer to quit line for counseling **1-800-QUIT-NOW**

5th A — **ARRANGE (Follow-Up)**

- Contact her on or near her quit date
- Follow-up at her next visit or by phone
- Encourage cessation for women who continue to use tobacco

3) Which of the following statements best describes the rules about smoking inside your home, even if no one who lives in your home is a smoker?

a) No one is allowed to smoke anywhere inside my home
b) Smoking is allowed in some rooms or at some times
c) Smoking is permitted anywhere inside my home

*Explain the risks of secondhand smoke (responses **"b and c"**), and benefits of eliminating secondhand smoke exposure (response **"a"**).

Alcohol and Substance Use:

State: "I ask all of my participants these questions because it is important to your health and the health of your baby."

Screening Questions:

1) Did any of your parents have a problem with alcohol or other drug use?
☐ Yes ☐ No ☐ Decline to answer

2) Do any of your friends have a problem with alcohol or other drug use?
☐ Yes ☐ No ☐ Decline to answer

3) Does your partner have a problem with alcohol or other drug use?
☐ Yes ☐ No ☐ Decline to answer

Alcohol and Substance Use (continued):

Screening Questions (continued):

4) In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?
☐ Yes ☐ No ☐ Decline to answer

5) Before you knew you were pregnant, how often did you drink any alcohol, including beer or wine, or use other drugs?
☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently

6) In the past month, how often did you drink any alcohol, including beer or wine, or use other drugs?
☐ Not at all ☐ Rarely ☐ Sometimes ☐ Frequently

Risk Assessment:

- **"No"** responses to all questions: Review benefits of abstinence.
- **"Yes"** response to Questions 1-3: Offer to provide information and/or connect her with the Local Management Entity (LME) in your county.

*Review the risk for potential alcohol and substance use and safety for the woman and her baby.

- **"Yes"** response to Question 4, and **"Sometimes or Frequently"** responses to Questions 5-6: Offer to connect her with the Alcohol Drug Council of NC **1-800-688-4232** or the LME in your county.

*Inform her that any alcohol or other drug use during pregnancy can be a problem for the health of the baby. There are no safe levels of usage.

Intimate Partner Violence (IPV):

State: "Because violence is so common in many women's lives and because there is help available for women being abused, I now ask every participant about domestic violence."

IPV Screening:

1) Within the past year—or since you have been pregnant—have you been hit, slapped, kicked or otherwise physically hurt by someone? □ Yes □ No

2) Are you in a relationship with a person who threatens or physically hurts you? □ Yes □ No

3) Has anyone forced you to have sexual activities that made you feel uncomfortable? □ Yes □ No

4) Does your partner ever criticize you or embarrass you in front of others? □ Yes □ No

5) Does your partner put you down or keep you from contacting family or friends? □ Yes □ No

*For any **"Yes"** responses, offer to connect her with local domestic violence resources. If she needs emergency help, call **911**.

Legal Issues:

State: "So that I will have a better understanding of your current situation…"

1) Are criminal charges pending against you? □ Yes □ No

2) Are you currently on probation or parole? □ Yes □ No

Comments:

Depression:

Since you've become pregnant, how often have you felt down, depressed, or hopeless? *(Circle one)*

a) Always
b) Often
c) Sometimes
d) Rarely
e) Never

*For responses **"a, b and c,"** recommend that she call her health care provider to discuss treatments to help her feel better. Contact your Local Management Entity (LME) for mental health services. If she is worried about hurting herself, call emergency **911.**

Comments:

Financial:

Currently, what are the primary sources of the participant's income/ financial resources? *(Check all that apply)*

☐ Food Stamps
☐ Participant's Employment
☐ Supplemental Security Income (SSI)
☐ WIC
☐ Work First
☐ Other _____

Does participant have financial support from the baby's father? ☐ Yes ☐ No

Can participant provide basic necessities for herself? ☐ Yes ☐ No

Housing:

State: "Tell me about the safety and stability of your home or neighborhood."

1) Do you have a safe place to live? ☐ Yes ☐ No
2) Is it temporary or permanent? ☐ Temp ☐ Perm
3) Do you live in Public Housing? ☐ Yes ☐ No
4) Do you have?
   a) Electricity ☐ Yes ☐ No
   b) Indoor Plumbing ☐ Yes ☐ No
   c) Heat and Air Conditioning ☐ Yes ☐ No
   d) Working Smoke Alarms ☐ Yes ☐ No
5) Are there firearms (guns) in the home? ☐ Yes ☐ No
   If yes, where are they kept? _____

* Make sure that they store firearms (guns) separately from ammunition and that the firearms (guns) are locked up.

Comments:

Coordinated Support Services

Document which support services were coordinated/referred during the pregnant assessment: (check all that apply)

☐ Breastfeeding/Lactation Consultant
☐ Child Care
☐ Childbirth Classes
☐ Domestic Violence
☐ Doula Services
☐ Education/School Enrollment/GED
☐ Employment/Vocational Rehabilitation
☐ Family Planning Services
☐ Financial Assistance (baby items, clothing, furniture, rent, etc.)
☐ Housing Assistance
☐ Medical/Prenatal Care
☐ Mental Health Services
☐ Parenting Education
☐ Smoking Cessation
☐ Substance Use/Abuse Services
☐ Transportation
☐ WIC
☐ Other, please specify: _____

Comments:

Instructions for
Healthy Beginnings Pregnant Assessment Form

Purpose: To collect information for newly enrolled pregnant Healthy Beginnings participants.

Instructions: Enter the date form initiated on page one. Complete the entire assessment within 30 days of enrollment, and sign and date when the form is completed on page four. Submit required information as instructed by the Healthy Beginnings Program Manager. File the original form in participant's program record.

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

_____
Staff Signature and Date

_____
Staff Printed Name