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 Update Log

____

____

____

Phone: ☐ Phone # change on Contact 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 ____

Relationship 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:

____

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

Healthy Beginnings Pregnant Assessment

Client ID#

Date Form Initiated:

Month		Day		Year			

Staff Initials:

Contact Type: ☐ Phone ☐ Home Visit ☐ Office

☐ Newborn HV/Hospital Visit ☐ 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/Dental Home:

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

____

Do you have a Dentist? ☐ Yes ☐ No
Name of Dentist

____

Are you receiving Prenatal Care?

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

Name of Prenatal Provider

____

Do you have a Pediatrician? ☐ Yes ☐ No

Name of Pediatrician

____

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

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

Father Involvement and Support:

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

List the names, genders, and ages of all other 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 _______________ (Inches) Pre-pregnancy Weight ___________ (Pounds)

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

Reproductive Life Planning:

1) Would you like to have any more children? ☐ Yes ☐ No

If yes, How many? _________When? ______________

2) How important is it to you to prevent pregnancy (until then)?

____

*Discuss birth control methods from most effective to least effective and what method(s) may fit her reproductive life plan. Recommend she discuss her plan and birth control methods with her provider.

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.

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?

☐ I didn't
☐ 1 to 3 times a week
☐ 4 to 6 times a week
☐ 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/Secondhand Smoke Exposure:

Conduct the 5As counseling intervention for quitting tobacco use.

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

☐ I have NEVER smoked, or have smoked FEWER THAN 100 cigarettes in my lifetime.
☐ I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now.
☐ I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.
☐ I smoke now, but I cut down on the number of cigarettes I smoke SINCE I found out I was pregnant.
☐ I smoke regularly now, about the same as BEFORE I found out I was pregnant.

- For **"first"** responses — Congratulate her. **Go to question #3**.
- For **"second & third"** responses — Congratulate her success in quitting and reinforce her decision to stay quit. **Go to question #3**.
- For **"fourth & fifth"** responses — **Go to Question #2**.

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

☐ Less than 1 cigarette
☐ 1 to 5 cigarettes
☐ 6 to 10 cigarettes
☐ 11 to 20 cigarettes
☐ 21 or more cigarettes

3) During the 3 months before you got pregnant, on average, how often did you use other tobacco products or any electronic nicotine delivery system (such as vape pens, e-cigarettes, hookah pens)?

☐ I didn't then
☐ More than once a day
☐ Once a day
☐ 2-6 days a week
☐ 1 day a week or less

4) On average, how often do you use other tobacco products or any electronic nicotine delivery system now?

☐ I don't now
☐ More than once a day
☐ Once a day
☐ 2-6 days a week
☐ 1 day a week or less

Name ______________________________ Date of Birth ______________________

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

5) 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?

☐ No one is allowed to smoke anywhere inside my home

☐ Smoking is allowed in some rooms or at some times

☐ Smoking is permitted anywhere inside my home

*Explain the risks of secondhand smoke exposure and the benefits of eliminating secondhand smoke exposure.

Edinburgh Postnatal Depression Scale (EPDS):

1st Screening Date _____ _____ _________
MM DD YYYY

Referral made? ☐ Yes ☐ No

*Follow the Healthy Beginnings EPDS Policy and Procedures for administering, scoring, interpreting, and action/referral.

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."

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

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."

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

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.

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
☐ Tobacco Cessation/QuitlineNC 1-800-QUIT-NOW
☐ Substance Use/Abuse Services
☐ Transportation
☐ WIC
☐ Other, please specify: ____________________________________

Notes:

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Instructions for Healthy Beginnings Pregnant Assessment Form

Purpose: To collect information for newly enrolled pregnant program participants.

Instructions: Complete the entire assessment within 30 days of enrollment. File the assessment in program participant's 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