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

Healthy Beginnings Postpartum 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 the participant have health insurance?

☐ Yes ☐ No

List Type of Insurance: ______________________________

____

Does the baby 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

____

Does your baby have a Primary Care Provider? ☐ Yes ☐ No

Name of Primary Care Provider

____

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, 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 and regularly use a car seat for your baby? ☐ 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)?

____

____

Baby's Name(s): ____________________

____

Baby's Gender: ☐ Female ☐ Male

Baby's Due Date:

___ MM ___ DD ___ YYYY

Baby's Date of Birth:

___ MM ___ DD ___ YYYY

Baby's Birth Weight:

___ Pounds ___ Ounces

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:

____

____

____

Pre-pregnancy BMI:

Pre-pregnancy BMI __________

Height ______________ (Feet and Inches) Pre-pregnancy Weight __________ (Pounds)

Postpartum BMI:

Do not obtain postpartum weight until 6 weeks after baby's birth.

Postpartum BMI __________

Height ______________ (Feet and Inches) Postpartum Weight __________ (Pounds)

Postpartum Care:

Since your new baby was born, have you had a postpartum checkup for yourself? *(A postpartum checkup is the regular checkup a woman has with her OB/GYN usually 2–6 weeks after giving birth.)*

☐ Yes Date Checkup Occurred ______________ (MM/DD/YYYY)

☐ No

Reproductive Life Planning

Pregnancy Intendedness:

1) Do you plan to have more children at any time in your future?
   a) Yes
   b) No (skip questions #2 & #3)
2) How many children would you like to have? ______________
3) How long would you like to wait until you become pregnant?

   ____

*Women with short interpregnancy intervals (less than 18 months) are more likely to experience poor birth outcomes.

Birth Control Method:

What kind of birth control method are you or your husband or partner using to keep from getting pregnant? *(Check all that apply)*

☐ None
☐ Tubes tied or blocked (female sterilization, Essure®, Adiana®)
☐ Vasectomy (male sterilization)
☐ Birth control pill
☐ Condoms
☐ Injection (Depo-Provera®)
☐ Contraceptive implant (Nexplanon®)
☐ Contraceptive patch (OrthoEvra®, vaginal ring, NuvaRing®)
☐ IUD (including Mirena®, ParaGard®, Skylar®)
☐ Natural family planning (including rhythm method)
☐ Withdrawal (pulling out)
☐ Not having sex (abstinence)
☐ Other (please specify) ____________________

Comments:

Breastfeeding:

1) Are you currently breastfeeding or feeding pumped milk to your new baby?
   a) Yes (skip questions #2 & #3)
   b) No
2) Did you ever breastfeed or pump breast milk to feed your new baby, even for a short period of time?
   a) Yes
   b) No (skip question #3)
3) How many weeks did you breastfeed or pump milk to feed your baby?
   a) _______Weeks
   b) Less than 1 week

Safe Sleep:

1) In which one position do you most often lay your baby down to sleep now?
   a) On his or her side
   b) On his or her back
   c) On his or her stomach
2) How often does your new baby sleep in the same bed with you or anyone else?
   a) Always
   b) Often
   c) Sometimes
   d) Rarely
   e) Never

*The safest sleep position for a baby is on their back for the first 12 months, or until the baby can roll from stomach to back on their own. It is not safe for babies to sleep in the same bed with anyone.

Name ______________________ Date of Birth ______________________

Lifestyle

Multivitamin/Folic Acid Consumption:

How often do you take a multivitamin now?

_____________ Days a Week

*Recommended that ALL women of childbearing age get 400 micrograms of folic acid every day, even if they are not trying to become pregnant. It is important to take before becoming pregnant to help reduce the risk of birth defects of the brain and spine (neural tube defects).

Tobacco Use/Smoking/Secondhand Smoke Exposure:

1) In the last three months of your pregnancy, how many cigarettes did you smoke on an average day?
   a) I didn't smoke then
   b) Less than 1 cigarette
   c) 1 to 5 cigarettes
   d) 6 to 10 cigarettes
   e) 11 to 20 cigarettes
   f) 21 or more cigarettes

2) How many cigarettes do you smoke on an average day now?
   a) I don't smoke now
   b) Less than 1 cigarette
   c) 1 to 5 cigarettes
   d) 6 to 10 cigarettes
   e) 11 to 20 cigarettes
   f) 21 or more cigarettes

   *Follow the 5As smoking cessation counseling for women who are currently smoking.

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"**).

Comments:

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

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 alcohol and other drug use can impact parenting, especially with the challenges of a new infant.

Comments:

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, 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

Depression:

Since your new baby was born, 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 the baby? ☐ 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 have any concerns about your child's safety at school or daycare? ☐ Yes ☐ No
4) Do you live in Public Housing? ☐ Yes ☐ No
5) 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
6) 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 postpartum assessment: (check all that apply)

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

Comments:

Instructions for
Healthy Beginnings Postpartum Assessment Form

Purpose: To collect information for newly enrolled postpartum 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