ATTACHMENT C

PRECONCEPTION, PREGNANCY, AND PARENTING INFORMATION FORM

Reference No.

Preconception, Pregnancy, and Parenting Information Form

DRAFT 3.3.14

[INSERT HRSA/MCHB LOGO]

OMB Control No 0915-0338
XX/XX/XXXX

ADMINISTRATIVE NOTES AND INSTRUCTIONS

[These instructions will be updated after the data collection system is developed. Instructions will also differ slightly for Healthy Start projects and comparison organizations.]

1. Overview of the Preconception, Pregnancy, and Parenting (3P's) Information Form

[Introduction for Healthy Start grantees only] The 3P's form represents a uniform data collection form that all Healthy Start grantees will use to obtain information about women participants, their children, and families. Data collected through the form will allow grantees to perform real-time internal analysis and share these data. It will meet the needs of grantees in managing their projects, and will allow the Maternal and Child Health Bureau (MCHB), Division of Healthy Start Program Services (DHSPS) to pool data and get a snapshot of what is happening at both the national and project levels. It will also provide essential information for the national evaluation of the Healthy Start program.

[Introduction for comparison sites only] The Health Resources and Services Administration's (HRSA), Maternal and Child Health Bureau (MCHB) wants to learn about the health of women, children, and families in your community. MCHB's mission is to ensure the health, safety and well-being of the nation's maternal and child health (MCH) population which include women, infants, children, adolescents, and their families. This form will help us gather important information about the care being delivered to and health of the MCH population that can be used by MCHB to inform its activities.

This form is designed to be completed via the web by participating organization staff using information provided by eligible women. [Healthy Start/comparison sites: **Eligible women include those that receive services from your organization on an ongoing systematic basis/Eligible women include those that are four to seven months postpartum that receive services from your organization].** The form should take approximately 30 minutes to complete with the woman. The information we obtain will be used for program improvement and research purposes only. All of the information that women provide will be kept confidential.

Below, we provide instructions for staff on completing the forms via the web with eligible women. We also provide instruction for completing each item on the form, including the questions and probes that staff can use to obtain the needed information from women, skip patterns, and other considerations when administering the form.

2. Periods for Collection of Information

[Healthy Start] This form was developed to capture information for a woman at enrollment (enrollment record) and throughout the fiscal year (fiscal year record). After a record is completed at enrollment, a new record should be generated for a woman at the beginning of each fiscal year. Information for services and outcomes can be periodically updated throughout the fiscal year. At the end of a fiscal year (May 30th) all records should be completed [in preparation for reporting to HRSA/MCHB to meet GPRA requirements].

[Comparison sites] The form was developed to collect information for women four to seven months postpartum served during April-June 2015, April-June 2017, and April-June 2019. All records completed by your organization will be considered as enrollment records.

3. Sections of the Form

The form is divided into 11 sections. Table 1 provides information about the number of items in each section and overall instructions for completing each section.

Table 1. Women, Children, and Families Form Sections

Section	Description	Items	Instructions for Section
	Administrative Use Only	1–7	This section should be completed for each new record. Staff should complete this section before meeting with clients to complete the rest of the form.
A	Enrollment and Demographic Information	A1–A19	This section should be completed with all clients for enrollment and fiscal year records. Certain items will be pre-populated in subsequent new records for a woman each fiscal year.

Section	Description	Items	Instructions for Section
B	Pregnancy Status	B1–B2	This section should be completed for enrollment and fiscal year records. Staff should reassess pregnancy status of clients each time information is collected.
C	Client Health/Risk Information	C1–C17	This section should be completed for enrollment and fiscal year records. Staff should reassess client health risk each time information is collected.
D	Previous Pregnancy Information	D1–D16	For enrollment records, this section should always be completed if a woman indicated in Section B that she had a previous pregnancy. For fiscal year records, this section should be completed only if a woman indicates that she completed a pregnancy in the past year.
E	Birth Outcomes and Postpartum Information	E1–E17	This section should be completed only with clients who fill in Section B for both enrollment and fiscal year records.
F	Child and Parenting Information	F1–F19	This section should be completed only with clients who indicated in Section E that they had a live birth for both enrollment and fiscal year records.
G	Health Education	G1–G21	This section should be completed with all clients for enrollment and fiscal year records.
H	Health Service Utilization	H1–H9	This section should be completed with all clients for enrollment and fiscal year records.
I	Client's Perspective on Her Community	I1–I5	This section should be completed with all clients for enrollment and fiscal year records.
J	Healthy Start Services (Administrative use only)	J1-J4	This section should be completed for fiscal year records based on Healthy Start records.

4. Completing the Form via Web

- Access the form at [INSERT WEB ADDRESS]
    - Start a new form by clicking on the "new record" button on the first page; search for an existing record by entering the client ID and/or date of birth. Organizations will have to keep a separate record that links name to client ID; this file linking name and ID will not be shared with or collected by MCHB.
    - A new record should be started for a woman at the beginning of each fiscal year and updated throughout the fiscal year. The same client ID can be used and the form will pre-populate certain fields that cannot change, such as birth date.
- After the form opens, the table of contents will appear. To begin the new form, navigate to "administrative information" by clicking on the appropriate button on the table of contents.
- When administering the form, be sure to read *all bolded instructions and question text* to the client. Mark the client's responses on the form by clicking on the appropriate box or typing text in the blank spaces on the screen. Ask the respondent the questions verbatim and enter her responses into the system; the respondent should not enter the information herself. After you complete the questions on one page, click the next button at the bottom of the page to continue. To go back to a previous page, click the back button.
- When you have to stop, you can log out of the form by closing your browser. You can return to the form later by going to the [URL] and searching for the record using client ID and/or date of birth.

When you reenter the form, your previous answers will be saved. You will be able to update and add information by navigating to the section of your choice from the table of contents. *For enrollment records, it is recommended that you complete the form within one week of beginning data collection. For fiscal year records, it is recommended that you make sure that all information is complete and up to date by May 30th*); the system will provide a flag if there are incomplete enrollment records with a start date of one week or more. If you have any questions about the form, please refer to the Healthy Start Information Form training manual or contact [NAME] via email [EMAIL] or by telephone at [TELEPHONE NUMBER].

ADMINISTRATIVE ONLY SECTION

ADMINISTRATIVE USE ONLY- FILL IN BEFORE INTERVIEWING CLIENT

1. CLIENT ID:
Enter the ID for the client as assigned

2. FISCAL YEAR OF DATA COLLECTION:
2014 = June 1, 2014 – May 30, 2015
2015 = June 1, 2015 – May 30, 2016
2016 = June 1, 2016 – May 30, 2017
2017 = June 1, 2017 – May 30, 2018

3. FULL NAME OF STAFF PERSON:
Enter the full name of the staff person who started the record.

4. TITLE OF STAFF PERSON:
Enter the title of the staff person that who started the record.

5. NAME OF ORGANIZATION:
Enter the name of organization at which the data collection is taking place

6. RECORD TYPE

1☐ Enrollment Record

2☐ Fiscal Year Record

7. ENROLLMENT DATE/ CURRENT DATE:
FOR HEALTHY START: Enter the client's date of enrollment in Healthy Start

FOR COMPARISON SITES: Enter the date that you began collecting information on the client using the form

|__|__| / |__|__| / |__|__|__|__|
Month Day Year

OMB Control No 0915-0338
XX/XX/XXXX

A. Enrollment and Demographic Information

To begin your enrollment in the [program/study], I'm going to ask for your date of birth.

A1. What is your date of birth?

PR MS Co Ph

IF CLIENT REFUSES: In order to proceed, we need to know your date of birth. I'd like to assure you that all information collected will remain confidential. Would you please give me your date of birth?

|__|__| / |__|__| / |__|__|__|__|

Month Day Year

A2. I'm going to read a list of categories. Please choose one or more of the following categories to describe your race. Are you American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, or White?

Select all that apply.

1 ☐ American Indian or Alaska Native
2 ☐ Asian
3 ☐ Black or African American
4 ☐ Native Hawaiian or Other Pacific Islander
5 ☐ White
d ☐ DON'T KNOW
r ☐ REFUSED

A3. Are you Hispanic or Latina?

Select one only.

1 ❍ Yes, of Hispanic/Latino origin
0 ❍ No, not of Hispanic/Latino origin
d ❍ DON'T KNOW
r ❍ REFUSED

A4. What is the zip code of where you live?

|__|__|__|__|__| **ZIP CODE**
d ❍ DON'T KNOW
r ❍ REFUSED

A5. Were you born in the United States, including the Virgin Islands?

Select one only.

1 ❍ Yes, born in the United States **SKIP TO A7**
0 ❍ No, not born in the United States
d ❍ DON'T KNOW **SKIP TO A7**
r ❍ REFUSED **SKIP TO A7**

A6. What country were you born in?

COUNTRY:
_____
d ❍ DON'T KNOW
r ❍ REFUSED

A7. What is the language you speak <u>the most</u> at home?

SLAITS #K1Q03 modified

Select one only.

1 ❍ English
2 ❍ Spanish
99 ❍ Other:
_____
d ❍ DON'T KNOW
r ❍ REFUSED

A8. What is the highest grade or year of school you have completed?

Select one only.

1 ❍ Less than high school
2 ❍ High school graduate or GED completed
3 ❍ Some college/ vocational school
4 ❍ College graduate
5 ❍ More than college
d ❍ DON'T KNOW
r ❍ REFUSED

A9. Are you currently married or living with a partner, separated, divorced, widowed, or were you never married and are not currently living with a partner?

1 ❍ Married or living with partner
2 ❍ Separated
3 ❍ Divorced
4 ❍ Widowed
5 ❍ Never married and not living with a partner
d ❍ DON'T KNOW
r ❍ REFUSED

A10. Now, I'm going to ask about health insurance. Please tell me all the types of health insurance that you have.

PRAMS Core Phase 6, #2 modified

SELECT ONE RESPONSE PER ROW

Do you have…	YES	NO	DON'T KNOW	REFUSED
a. Medicaid [LOCAL PROGRAM NAME]?	1 ❍	2 ❍	d ❍	r ❍
b. CHIP [LOCAL PROGRAM NAME]?	1 ❍	2 ❍	d ❍	r ❍
c. Health insurance from your job or the job of your husband, partner, or parents?	1 ❍	2 ❍	d ❍	r ❍
d. Health insurance that you or someone else paid for (not from a job)?	1 ❍	2 ❍	d ❍	r ❍
e. TRICARE or other military health care?	1 ❍	2 ❍	d ❍	r ❍
f. Indian Health Service?	1 ❍	2 ❍	d ❍	r ❍
g. Indigent Care Program [LOCAL PROGRAM NAME]?	1 ❍	2 ❍	d ❍	r ❍

A11. Are you on WIC also known as the Special Supplemental Nutrition Program for Women, Infants, and Children?

Select one only.

1 ❍ Yes
0 ❍ No
d ❍ DON'T KNOW
r ❍ REFUSED

A12. TANF (Temporary Assistance for Needy Families) is a program that gives cash assistance to families; it is sometimes called welfare. Are you receiving TANF benefits?

Select one only.

1 ❍ Yes
0 ❍ No
d ❍ DON'T KNOW
r ❍ REFUSED

A13. What is your yearly total household income before taxes? Include your income, your husband's or partner's income, and any other income you may have received.

Select one only.

1 ❍ Less than $10,000
2 ❍ $10,000 to $14,999
3 ❍ $15,000 to $19.999
4 ❍ $20,000 to $24,999
5 ❍ $25,000 to $34,999
6 ❍ $35,000 to $49,999
7 ❍ $50,000 or more
d ❍ DON'T KNOW
r ❍ REFUSED

A14a. Are you currently working at a paying job?

Select one only.

1 ❍ Yes
0 ❍ No **SKIP TO A15**
d ❍ DON'T KNOW **SKIP TO A15**
r ❍ REFUSED **SKIP TO A15**

A14b. Are you working 35 or more hours per week or less than 35 hours per week?

Select one only.

1 ❍ 35 or more hours per week
2 ❍ less than 35 hours per week
d ❍ DON'T KNOW
r ❍ REFUSED

A15. I would like to ask you about your current housing. Do you own a place, rent a place, live in public housing, live with your parents, live at a shelter, or are homeless?

Select one only.

1 ❍ Owns a place
2 ❍ Rents a place
3 ❍ Lives in public housing
4 ❍ Lives with parents
❍ Lives at a shelter or homeless **SKIP TO SECTION B**
6 ❍ Some other arrangement:
_____
d ❍ DON'T KNOW
r ❍ REFUSED

A16. Counting yourself, how many people (ages 18 or older) live in the same house, apartment, or trailer as you? Please count the number of people who sleep there four or more nights a week.

|__|__| **TOTAL NUMBER OF ADULTS AGE 18 OR OLDER**
d ❍ DON'T KNOW
r ❍ REFUSED

A17. Which adults live in the same house, apartment, or trailer as you now? Please tell me for the adults who sleep there four or more nights a week.

Select all that apply.

1 ☐ Husband or partner
2 ☐ Mother
3 ☐ Father
4 ☐ Husband or partner's parents
5 ☐ Other family member or relative
6 ☐ Friend or roommate
7 ☐ Other:
_____
d ☐ DON'T KNOW
r ☐ REFUSED

A18. How many babies, children, and teenagers (under 18 years of age) live in the same house, apartment, or trailer as you?

|__|__| **TOTAL NUMBER OF BABIES, CHILDREN AND TEENAGERS UNDER AGE 18 (IF NONE, ENTER 0)**
d ❍ DON'T KNOW
r ❍ REFUSED

A18a. How many of the babies, children, and teenagers (under 18 years of age) that live with you are male?

|__|__| **TOTAL NUMBER OF MALE BABIES, CHILDREN AND TEENAGERS UNDER AGE 18 (IF NONE, ENTER 0)**
d ❍ DON'T KNOW
r ❍ REFUSED

A18b. How many of the babies, children, and teenagers (under 18 years of age) that live with you are female?

|__|__| **TOTAL NUMBER OF FEMALE BABIES, CHILDREN AND TEENAGERS UNDER AGE 18 (IF NONE, ENTER 0)**
d ❍ DON'T KNOW
r ❍ REFUSED

IF A18 = 0, DON'T KNOW OR REFUSED, GO TO SECTION B. OTHERWISE, CONTINUE TO A19.

A19. Thinking about all the people under 18 years of age who live in the same house, apartment, or trailer as you…

a. Less than 12 months old?	|__|__|	d ❍	r ❍
b. Aged 1 year to 5 years?	|__|__|	d ❍	r ❍
c. Aged 6 years to 17 years?	|__|__|	d ❍	r ❍

B. Pregnancy Status

Next, I'm going to ask you if you are currently pregnant and if you have been pregnant before.

B1. **Are you pregnant now?**
PROBE IF CLIENT DOESN'T KNOW: Do you think you are probably pregnant or not?

NSFG

Select one only.

PRAMS Co

1 ❍ Yes
0 ❍ No **SKIP TO B2**
d ❍ DON'T KNOW **SKIP TO B2**
r ❍ REFUSED **SKIP TO B2**

B1a. **How many weeks or months pregnant are you now?**

NSFG

Select one only.

|___|___| WEEKS OR
|___|___| MONTHS
d ❍ DON'T KNOW
r ❍ REFUSED

B2. **[IF B1 = 1 (Yes): Not including this pregnancy, how]/ [IF B1 = 0 (No): How] many times have you been pregnant in your life?**

NSFG Female Questionarre #BB-1

Select one only.

|___|___| PREGNANCIES
d ❍ DON'T KNOW
r ❍ REFUSED

C. Client's Health Risks/ Information

The next questions will be about your health and other things you do to take care of yourself.

C1. **In general, would you say that your overall <u>health</u> is excellent, very good, good, fair, or poor?**

SLAITS #K5 Q21

Select one only.

1 ❍ Excellent
2 ❍ Very good
3 ❍ Good
4 ❍ Fair
5 ❍ Poor
d ❍ DON'T KNOW
r ❍ REFUSED

C2. **In general, would you say that your mental and emotional health is excellent, very good, good, fair, or poor?**

SLAITS #K5 Q22

Select one only.

1 ❍ Excellent
2 ❍ Very good
3 ❍ Good
4 ❍ Fair
5 ❍ Poor
d ❍ DON'T KNOW
r ❍ REFUSED

C3. **How tall are you without shoes? Provide your height in feet and inches.**

PRAMS Core Phase 6 #5 mo

|___| FEET AND |___|___| INCHES
d ❍ DON'T KNOW
r ❍ REFUSED

C4. **[IF B1 = 1 (Yes): Just before you got pregnant with your new baby, how much did you weigh?]/ [IF B1 = 0 (No): How much do you weigh now?] Provide your weight in pounds.**

PRAMS Core Phase 6 #4 mo

|___|___|___| POUNDS
d ❍ DON'T KNOW
r ❍ REFUSED

C5. **Now I am going to ask you about certain medical conditions. Have you <u>ever</u> been told by a doctor or other health professional that you had <u>hypertension</u>, also called high blood pressure?**

PRAMS Stan

Select one only.

1 ❍ Yes
0 ❍ No
d ❍ DON'T KNOW
r ❍ REFUSED

C6. **Have you <u>ever</u> been diagnosed with <u>Type 1 or Type 2 diabetes</u>? This is not the same as gestational diabetes or diabetes that starts during pregnancy.**

PRAMS Stan

Select one only.

1 ❍ Yes
0 ❍ No
d ❍ DON'T KNOW

r ❍ REFUSED

C7. How many times a week do you take a multivitamin, prenatal vitamin, or folic acid vitamin?

PRAMS Stan

Select one only.

0 ❍ 0 times per week
1 ❍ 1 to 3 times a week
2 ❍ 4 to 6 times a week
3 ❍ Every day of the week
d ❍ DON'T KNOW
r ❍ REFUSED

C8. Do you currently smoke?

PRAMS

Select one only.

1 ❍ Yes
0 ❍ No **SKIP TO C9**
d ❍ DON'T KNOW **SKIP TO C9**
r ❍ REFUSED **SKIP TO C9**

C8a. How many cigarettes do you smoke on an average day?

PRAMS Cor

|___|___|___| CIGARETTES (NOTE: A PACK HAS 20 CIGARETTES)

d ❍ DON'T KNOW **SKIP TO C9**
r ❍ REFUSED **SKIP TO C9**

C8b. Did a doctor, nurse, or other health care worker ever advise you to quit smoking?

PRAMS Standard Phase 6 #AA2 modified

Select one only.

1 ❍ Yes
0 ❍ No
d ❍ DON'T KNOW
r ❍ REFUSED

C9. Which of the following statements best describes the rules about smoking inside your home now: No one is allowed to smoke anywhere inside my home, smoking is allowed in some rooms or at some times, or smoking is permitted anywhere inside my home?

PRAMS

Select one only.

1 ❍ No one is allowed to smoke anywhere inside my home
2 ❍ Smoking is allowed in some rooms or at some times
3 ❍ Smoking is permitted anywhere inside my home
d ❍ DON'T KNOW
r ❍ REFUSED

C10. On average, about how many hours per day are you in the same room or vehicle with another person who is smoking?

PRAMS Standard Phase 6 #AA4 modified

|___|___| HOURS PER DAY (ENTER 1 HOUR THROUGH 24 HOURS)

Select one only.

1 ❍ Client spends <u>less than one hour per day</u> in a room or vehicle with somebody who is smoking
0 ❍ Client is <u>never</u> in a room or vehicle with someone who is smoking
d ❍ DON'T KNOW
r ❍ REFUSED

C11. Do you have any alcoholic drinks?

PRAMS Cor

Select one only.

1 ❍ Yes
0 ❍ No **SKIP TO C12**
d ❍ DON'T KNOW **SKIP TO C12**
r ❍ REFUSED **SKIP TO C12**

C11a. How many alcoholic drinks do you have in an average week?

PRAMS Cor

A drink is one glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

Select one only.

1 ❍ Less than one drink per week
2 ❍ 1 to 3 drinks per week
3 ❍ 4 to 6 drinks per week
4 ❍ 7 to 13 drinks per week
5 ❍ 14 or more drinks per week
d ❍ DON'T KNOW
r ❍ REFUSED

C12. **How often do you wear a seatbelt when you drive a car? Would you say never, seldom, sometimes, or always?**

NSDUH#R

IF CLIENT SAYS SHE DOES NOT DRIVE A CAR: How often do you wear a seatbelt when you ride in the front passenger seat of a car?

Select one only.

- 0 ❍ Never
- 1 ❍ Seldom
- 2 ❍ Sometimes
- 3 ❍ Always
- 4 ❍ NOT APPLICABLE, CLIENT NEVER RIDES IN A CAR
- d ❍ DON'T KNOW
- r ❍ REFUSED

C13. **How long ago did you last have a flu vaccination? Would you say less than six months ago, six months to a year ago, more than a year ago, or never?**

PRAMSStan

Select one only.

- 1 ❍ Less than six months ago
- 2 ❍ Six months to one year ago
- 3 ❍ More than one year ago
- 4 ❍ Never
- d ❍ DON'T KNOW
- r ❍ REFUSED

C14. **How long ago did you last have your teeth cleaned by a dentist/hygienist? Would you say less than six months ago, six months to a year ago, more than a year ago, or never?**

PRAMSCor

Select one only.

- 1 ❍ Less than six months ago
- 2 ❍ six months to one year ago
- 3 ❍ More than one year ago
- 4 ❍ Never
- d ❍ DON'T KNOW
- r ❍ REFUSED

C15. **The next question is about the test for HIV, the virus that causes AIDS. When was the last time you were tested for HIV? Would you say less than six months ago, six months to a year ago, more than a year ago, or never? Do <u>not</u> count testing that might have happened as part of blood donations.**

NSFG Female Questionnaire revised #HE-2 modified

Select one only.

- 1 ❍ Less than six months ago
- 2 ❍ Six months to one year ago
- 3 ❍ More than one year ago
- 4 ❍ Never
- d ❍ DON'T KNOW
- r ❍ REFUSED

C16. **Chlamydia is a common sexually transmitted infection (STI) caused by a bacterium. It can infect both men and women. When was the last time you were tested for Chlamydia? Would you say less than 6 months ago, 6 months to a year ago, more than a year ago, or never?**

NSFG Female Questionnaire #HE-2 modified

Select one only.

- 1 ❍ Less than six months ago
- 2 ❍ Six months to one year ago
- 3 ❍ More than one year ago
- 4 ❍ Never
- d ❍ DON'T KNOW
- r ❍ REFUSED

C17. **When was the last time you were tested for STIs other than HIV and Chlamydia? Other STIs may include gonorrhea, herpes, or syphilis. Would you say less than six months ago, six months to a year ago, more than a year ago, or never?**

NSFGF

Select one only.

- 1 ❍ Less than six months ago
- 2 ❍ Six months to one year ago
- 3 ❍ More than one year ago
- 4 ❍ Never
- d ❍ DON'T KNOW
- r ❍ REFUSED

D. Previous Pregnancy Information

This section should be completed for <u>women with a previous pregnancy only</u> (B2= 1 or more). Continue to SECTION G if client did not have a previous pregnancy (B2 = 0, don't know or refused).

FOR WOMEN WITH A PREVIOUS PREGNANCY (B2 = 1 or more) and RECORD TYPE = ENROLLMENT, SKIP TO D2.

FOR WOMEN WITH A PREVIOUS PREGNANCY (B2 = 1 or more) AND RECORD TYPE = FISCAL YEAR, CONTINUE to D1.

D1. **You said earlier that you had been pregnant before. Now, I would like to know if you had any pregnancies that were completed in the past year to see if we should update the information we have about your previous pregnancies. Have you had a pregnancy that was completed in the past 12 months?**

Select one only.

1 ❍ Yes
0 ❍ No **SKIP TO SECTION E**
d ❍ DON'T KNOW **SKIP TO SECTION E**
r ❍ REFUSED **SKIP TO SECTION E**

D2. *PRAMS Core Phase*

Now, I would like to ask you a few questions about what you did when you were pregnant before. Please answer these questions for the last time you were pregnant.

How many weeks or months pregnant were you when you had your first visit for prenatal care during your last pregnancy? Do not count a visit that was only for a pregnancy test or only for WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children).

PROBE: Please tell me for the last time you were pregnant.

Select one only.

|__|__| WEEKS PREGNANT OR
|__|__| MONTHS PREGNANT
0 ❍ Did not go for prenatal care
d ❍ DON'T KNOW
r ❍ REFUSED

D3. *PRAMS Standard Phase 6 #II1 modified*

How much weight in pounds did you gain during your last pregnancy?

Select one only.

|__|__|__| POUNDS (ENTER 0 IF CLIENT'S WEIGHT DID NOT CHANGE)

1 ❍ CLIENT LOST WEIGHT DURING PREGNANCY
d ❍ DON'T KNOW
r ❍ REFUSED

D4. *PRAMS Core Phase 6 #24 modified*

Were you diagnosed with preeclampsia during your last pregnancy?

Preeclampsia is when you have high blood pressure, swelling, and protein in your urine that you didn't have before you got pregnant.

Select one only.

1 ❍ Yes
0 ❍ No
d ❍ DON'T KNOW
r ❍ REFUSED

D5. *PRAMS Core Phase 6 #24, 7 modified*

Were you diagnosed with gestational diabetes during your last pregnancy?

Gestational diabetes is when you have high blood sugar when you didn't have it before you got pregnant.

Select one only.

1 ❍ Yes
0 ❍ No
d ❍ DON'T KNOW
r ❍ REFUSED

D6. *PRAMS Stan*

During the last three months of your last pregnancy, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?

Select one only.

0 ❍ Client did not take a multivitamin, prenatal vitamin or folic acid vitamin at all
1 ❍ 1 to 3 times per week
2 ❍ 4 to 6 times per week

d ❍ DON'T KNOW
r ❍ REFUSED

D7. **In the last three months of your last pregnancy, did you smoke cigarettes?**

PRAMSC or

Select one only.

1 ❍ Yes
0 ❍ No **SKIP TO D8**
d ❍ DON'T KNOW **SKIP TO D8**
r ❍ REFUSED **SKIP TO D8**

D7a. **In the last three months of your last pregnancy, how many cigarettes did you smoke on an average day? (A pack has 20 cigarettes.)**

PRAMSC

|__|__|__| CIGARETTES

d ❍ DON'T KNOW **SKIP TO D8**
r ❍ REFUSED **SKIP TO D8**

D7b. **During any of your prenatal care visits during your last pregnancy, did a doctor, nurse, or other health care worker advise you to quit smoking?**

PRAMSSt

Select one only.

1 ❍ Yes
0 ❍ No
d ❍ DON'T KNOW
r ❍ REFUSED

D8. **Which of the following statements best describes the rules about smoking inside your home during your last pregnancy?**

PRAMSC

No one was allowed to smoke anywhere inside my home, smoking was allowed in some rooms or at some times, or smoking was permitted anywhere inside my home?

Select one only.

1 ❍ No one was allowed to smoke anywhere inside my home
2 ❍ Smoking was allowed in some rooms or at some times
3 ❍ Smoking was permitted anywhere inside my home
d ❍ DON'T KNOW
r ❍ REFUSED

D9. **During your last pregnancy, about how many hours a day, on average, were you in the same room or vehicle with another person who was smoking?**

PRAMSSt

Select one only.

|__|__| HOURS PER DAY

0 ❍ Client was never in a room or vehicle with someone who was smoking
1 ❍ Client spend less than one hour per day in a room or vehicle with somebody who was smoking
d ❍ DON'T KNOW
r ❍ REFUSED

D10. **During the last three months of your last pregnancy, how many alcoholic drinks did you have in an average week?**

PRAMS Core Phase 8 #31a, 32a modified

PROBE: A drink is one glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

Select one only.

0 ❍ CLIENT DID NOT DRINK
1 ❍ Less than one drink per week
2 ❍ 1 to 3 drinks per week
3 ❍ 4 to 6 drinks per week
4 ❍ 7 to 13 drinks per week
5 ❍ 14 or more drinks per week
d ❍ DON'T KNOW
r ❍ REFUSED

D11. **How often did you wear a seatbelt when you drove a car during your last pregnancy? Would you say never, seldom, sometimes, or always?**

NSDUH, #

PROBE IF CLIENT SAYS SHE DOES NOT DRIVE A CAR: How often did you wear a seatbelt when you rode in the front passenger seat of a car?

Select one only.

0 ❍ Never
1 ❍ Seldom
2 ❍ Sometimes
3 ❍ Always
4 ❍ NOT APPLICABLE, CLIENT NEVER RIDES IN A CAR
d ❍ DON'T KNOW
r ❍ REFUSED

D12. **Did you get a flu vaccination during your last pregnancy?**

PRAMS, St

Select one only.

1 ❍ Yes
0 ❍ No

NS Fe Qu re HE mo

d ❍ DON'T KNOW
r ❍ REFUSED

D13. Did you have your teeth cleaned by a dentist/hygienist during your last pregnancy?

PRAMS, C

Select one only.

1 ❍ Yes
0 ❍ No
d ❍ DON'T KNOW
r ❍ REFUSED

D14. When were you tested for HIV (the virus that causes AIDS) during your last pregnancy? Was it during the first three months, the second three months, the last three months, or never?

NSFG

Select one only.

1 ❍ During first three months of most recent pregnancy
2 ❍ During second three months of most recent pregnancy
3 ❍ During last three months of most recent pregnancy
4 ❍ Not tested during most recent pregnancy
d ❍ DON'T KNOW
r ❍ REFUSED

D15. When were you tested for Chlamydia during your last pregnancy? Was it during the first three months, the second three months, the last three months, or never?

PROBE: Chlamydia is a common sexually transmitted infection (STI) caused by a bacterium. It can infect both men and women.

Select one only.

1 ❍ During first three months of most recent pregnancy
2 ❍ During second three months of most recent pregnancy
3 ❍ During last three months of most recent pregnancy
4 ❍ Not tested during most recent pregnancy
d ❍ DON'T KNOW
r ❍ REFUSED

D16. When were you tested for STIs other than HIV and Chlamydia during your last pregnancy? Was it during the first three months, the second three months, the last three months, or never?

NSFG

PROBE: Other STIs may include gonorrhea, herpes, or syphilis.

Select one only.

1 ❍ During first three months of most recent pregnancy
2 ❍ During second three months of most recent pregnancy
3 ❍ During last three months of most recent pregnancy
4 ❍ Not tested during most recent pregnancy
d ❍ DON'T KNOW
r ❍ REFUSED

E. Birth Outcomes and Postpartum Information

This section should be completed only for <u>women with a previous pregnancy</u> (B2 = 1 or more) who responded to item D2 in the preceding Section. Continue to SECTION G if client did not have a previous pregnancy (B2 = 0, DON'T KNOW, or REFUSED).

Now, I'd like to ask about the outcome of the pregnancies you had before.

E1. How many of your children were delivered vaginally (naturally)?

NSFG

|___|___| **NUMBER. IF NONE, ENTER "0"**

d ❍ DON'T KNOW
r ❍ REFUSED

E2. How many of your children were delivered by cesarean delivery (c-section)?

NSFG

|___|___| **NUMBER. IF NONE, ENTER "0" AND SKIP TO E3**

d ❍ DON'T KNOW **SKIP TO E3**
r ❍ REFUSED **SKIP TO E3**

E2A. Did you have a cesarean sections (c-sections) before you were 39 weeks pregnant?

Select one only.

1 ❍ Yes

0 ❍ No **SKIP TO E3A**

d ❍ DON'T KNOW **SKIP TO E3A**

r ❍ REFUSED **SKIP TO E3A**

E2B. What were the reasons you had a cesarean section (c-section) before you were 39 weeks pregnant? Was it because…

PRAMS

Select all that apply.

1 ☐ You had a c-section before

2 ☐ The baby was in the wrong position

3 ☐ The baby was past the due date

4 ☐ Your doctor was worried that the baby was too big

5 ☐ You had a medical condition that made going into labor dangerous

6 ☐ Your doctor or nurse tried to induce labor, but it didn't work

7 ☐ Your labor was taking too long

8 ☐ The fetal monitor showed that the baby was having problems during labor

9 ☐ You wanted to schedule your delivery

10 ☐ You didn't want to have the baby vaginally

11 ☐ Some other reason(s):

_____

d ☐ DON'T KNOW

r ☐ REFUSED

E3A. A woman can unintentionally lose her pregnancy because of an ectopic or tubal pregnancy, miscarriage, spontaneous abortion, or stillbirth.

NSFG Female Outcomes

How many of your pregnancies were lost unintentionally?

|___|___| **NUMBER. IF NONE, ENTER "0" AND SKIP TO E4A**

d ❍ DON'T KNOW **SKIP TO E4A**

r ❍ REFUSED **SKIP TO E4A**

E3B. How many months or weeks had you been pregnant when that last happened?

NSFG Female Questionnaire #BC-1 modified

|___| MONTHS OR

|___|___| WEEKS

d ❍ DON'T KNOW

r ❍ REFUSED

E4A. An abortion is when a woman undergoes a procedure to intentionally end her pregnancy. She can choose to do this for medical or personal reasons.

NSFG

How many of your pregnancies ended in abortion?

|___|___| **NUMBER, IF NONE, ENTER "0" AND SKIP TO E5**

d ❍ DON'T KNOW **SKIP TO E5**

r ❍ REFUSED **SKIP TO E5**

E4B. How many months or weeks had you been pregnant when that last happened?

NSFG

|___| MONTHS OR

|___|___| WEEKS

d ❍ DON'T KNOW

r ❍ REFUSED

IF E1 or E2 = 1 OR MORE, CONTINUE TO E5. OTHERWISE, SKIP TO SECTION G

Now I am going to ask you some questions about your children.

Fill in the following for up to three live births. Ask questions E5 through E11 for the first delivery, then repeat E5 through E11 for the second delivery (if applicable) and then repeat E5 through E11 a third time for the most recent delivery (if applicable).

		First delivery	Second delivery	*If more than two deliveries:* Most recent delivery
E5.		**What is the date of birth for your <u>first</u> child?** |__|__| / |__|__| / |__|__|__|__| Month Day Year d ❍ DON'T KNOW r ❍ REFUSED	**What is the date of birth for your <u>second</u> child?** |__|__| / |__|__| / |__|__|__|__| Month Day Year d ❍ DON'T KNOW r ❍ REFUSED	**What is the date of birth for your <u>last</u> child?** |__|__| / |__|__| / |__|__|__|__| Month Day Year d ❍ DON'T KNOW r ❍ REFUSED
E6.		**Where was your <u>first</u> child delivered? Was it at a hospital, birthing center, home, or some other place?** *Select one only.* 1 ❍ Hospital 2 ❍ Birthing center 3 ❍ Home 4 ❍ Other place: _____ d ❍ DON'T KNOW r ❍ REFUSED	**Where was your <u>second</u> child delivered? Was it at a hospital, birthing center, home, or some other place?** *Select one only.* 1 ❍ Hospital 2 ❍ Birthing center 3 ❍ Home 4 ❍ Other place: _____ d ❍ DON'T KNOW r ❍ REFUSED	**Where was your <u>last</u> child delivered? Was it at a hospital, birthing center, home, or some other place?** *Select one only.* 1 ❍ Hospital 2 ❍ Birthing center 3 ❍ Home 4 ❍ Other place: _____ d ❍ DON'T KNOW r ❍ REFUSED
E7.	*NSFG Female Questionnaire #BC-7 modified*	**How many weeks had you been pregnant when your <u>first</u> child was born?** |__|__| **WEEKS** d ❍ DON'T KNOW r ❍ REFUSED	**How many weeks had you been pregnant when your <u>second</u> child was born?** |__|__| **WEEKS** d ❍ DON'T KNOW r ❍ REFUSED	**How many weeks had you been pregnant when your <u>last</u> child was born?** |__|__| **WEEKS** d ❍ DON'T KNOW r ❍ REFUSED
E8.	*NSFG Female Questionnaire #BD-3*	**How much did your <u>first</u> child weigh at birth? Report the weight in pounds and ounces.** |__|__| **LBS AND** |__| **OZS** d ❍ DON'T KNOW r ❍ REFUSED	**How much did your <u>second</u> child weigh at birth? Report the weight in pounds and ounces.** |__|__| **LBS AND** |__| **OZS** d ❍ DON'T KNOW r ❍ REFUSED	**How much did your <u>last</u> child weigh at birth? Report the weight in pounds and ounces.** |__|__| **LBS AND** |__| **OZS** d ❍ DON'T KNOW r ❍ REFUSED

	First delivery	Second delivery	*If more than two deliveries:* Most recent delivery
E9.	**Which of the following types of nursery did your first child spend time in after birth: a full term nursery, a special care nursery, a neonatal intensive care unit (also known as a NICU), or did your infant stay in the room with you?** *Select one only.* 1 ❍ Full term nursery 2 ❍ Special care nursery 3 ❍ Neonatal intensive care unit 4 ❍ Stayed in room 5 ❍ Other:_____ d ❍ DON'T KNOW r ❍ REFUSED	**Which of the following types of nursery did your second child spend time in after birth:a full term nursery, a special care nursery, a neonatal intensive care unit (also known as a NICU), or did your infant stay in the room with you?** *Select one only.* 1 ❍ Full term nursery 2 ❍ Special care nursery 3 ❍ Neonatal intensive care unit 4 ❍ Stayed in room 5 ❍ Other:_____ d ❍ DON'T KNOW r ❍ REFUSED	**Which of the following types of nursery did your last child spend time in after birth: a full term nursery, a special care nursery, a neonatal intensive care unit (also known as a NICU) or did your infant stay in the room with you?** *Select one only.* 1 ❍ Full term nursery 2 ❍ Special care nursery 3 ❍ Neonatal intensive care unit 4 ❍ Stayed in room 5 ❍ Other:_____ d ❍ DON'T KNOW r ❍ REFUSED
E10.	**What types of medical conditions was your first child diagnosed with after delivery, if any? Examples of medical conditions are a birth defect, hearing risk diagnosis, vision risk diagnosis, and metabolic disorder.** **LIST CONDITIONS:_____** 0 ❍ No medical conditions d ❍ DON'T KNOW r ❍ REFUSED	**What types of medical conditions was your second child diagnosed with after delivery, if any? Examples of medical conditions are a birth defect, hearing risk diagnosis, vision risk diagnosis, and metabolic disorder.** **LIST CONDITIONS:_____** 0 ❍ No medical conditions d ❍ DON'T KNOW r ❍ REFUSED	**What types of medical conditions was your last child diagnosed with after delivery, if any? Examples of medical conditions are a birth defect, hearing risk diagnosis, vision risk diagnosis, and metabolic disorder.** **LIST CONDITIONS:_____** 0 ❍ No medical conditions d ❍ DON'T KNOW r ❍ REFUSED
E11.	**How many days did your first child spend in the hospital after delivery?** **|___|___|___| DAYS** d ❍ DON'T KNOW r ❍ REFUSED	**How many days did your second child spend in the hospital after delivery?** **|___|___|___| DAYS** d ❍ DON'T KNOW r ❍ REFUSED	**How many days did your last child spend in the hospital after delivery?** **|___|___|___| DAYS** d ❍ DON'T KNOW r ❍ REFUSED

E12. Which of the following types of people were in the room with you at your last delivery? PROBE IF CLIENT HAD MORE THAN ONE LIVE BIRTH: Please tell me for your last child.

SELECT ONE RESPONSE PER ROW

Was there a(n)…	YES	NO	DON'T KNOW	REFUSED
a. OB/GYN?	1 ❍	2 ❍	d ❍	r ❍
b. Nurse?	1 ❍	2 ❍	d ❍	r ❍
c. Midwife?	1 ❍	2 ❍	d ❍	r ❍
d. Doula?	1 ❍	2 ❍	d ❍	r ❍
e. Partner or spouse?	1 ❍	2 ❍	d ❍	r ❍
f. Family member or friend?	1 ❍	2 ❍	d ❍	r ❍
e. Another person:_____?	1 ❍	2 ❍	d ❍	r ❍

E13. Was your child seen by a health care worker, like a doctor or nurse, for a one-week checkup after he or she was born?

PRAMS Co

PROBE IF CLIENT HAD MORE THAN ONE LIVE BIRTH: Please tell me for your last child.

Select one only.

1 ❍ Yes
0 ❍ No
d ❍ DON'T KNOW
r ❍ REFUSED

E14. Since your child was born, have you had a postpartum checkup for yourself? A postpartum checkup is the regular checkup a woman has after she gives birth.

PRAMS Standard Phase 6

PROBE IF CLIENT HAD MORE THAN ONE LIVE BIRTH: Please tell me for your last child.

Select one only.

1 ❍ Yes
0 ❍ No
d ❍ DON'T KNOW
r ❍ REFUSED

I will read a list of feelings and experiences that women sometimes have after childbirth. [IF LAST CHILD WAS DELIVERED LESS THAN 3 MONTHS AGO: How often have you felt or experienced these things in this way after giving birth to your last baby?]/ [IF LAST CHILD WAS DELIVERED MORE THAN 3 MONTHS AGO: How often did you feel or experience these things this way during the three months after your baby was born?] Please think about the time after your last child was delivered.

SELECT ONE RESPONSE PER ROW

How often have you felt…	Never	Rarely	Sometimes	Often	Always	DON'T KNOW	REFUSED
E15. *PRAMS Core Phase 6, #53 modified* **Down, depressed, or sad? Would you say never, rarely, sometimes, often or always?**	❍	❍	3 ❍	❍	❍	❍	r ❍
E16. *PRAMS Core Phase 6, #53 modified* **Hopeless? Would you say never, rarely, sometimes, often or always?**	❍	❍	3 ❍	❍	❍	❍	r ❍

E17. *PRAMS Core Phase 6, #53 modified*	**Slowed down? Would you say never, rarely, sometimes, often or always?**	❍	❍	3 ❍	❍	❍	❍	r ❍

F. Child and Parenting Information

F1. **Now, I'd like to ask some questions about the last child you delivered. Please choose one or more of the following categories to describe your child's race. Is your child American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, or White?**

Select all that apply.

1 ☐ American Indian or Alaska Native
2 ☐ Asian
3 ☐ Black or African American
4 ☐ Native Hawaiian or Other Pacific Islander
5 ☐ White
d ☐ DON'T KNOW
r ☐ REFUSED

F2. **Is your child of Hispanic, Latino, or Spanish origin?**

PROBE: Please tell me for your last child.

Select one only.

1 ❍ Yes, of Hispanic/Latino origin
0 ❍ No, not of Hispanic/Latino origin
d ❍ DON'T KNOW
r ❍ REFUSED

F3. **Where did you get information about breastfeeding?**

Select all that apply.

PRAMS Standard Phase 6, #B3, B7 modified

1 ☐ WIC nutrition program
2 ☐ Hospital staff gave client the information about breastfeeding
3 ☐ Healthy Start staff gave client information about breastfeeding
4 ☐ No information received about breastfeeding
d ☐ DON'T KNOW
r ☐ REFUSED

F4. **Did you ever breastfeed or pump breast milk to feed your new baby after delivery, even for a short period of time?**

PROBE: Please tell me for your last child.

Select one only.

1 ❍ Yes
0 ❍ No **SKIP TO F5**
d ❍ DON'T KNOW **SKIP TO F5**
r ❍ REFUSED **SKIP TO F5**

F4a. **How many weeks or months did you breastfeed or pump milk to feed your child?**

|__|__| WEEKS OR
|__|__| MONTHS

d ❍ DON'T KNOW
r ❍ REFUSED

F5. **Would you say that, in general, your child's overall health is excellent, very good, good, fair, or poor?**

PROBE: Please tell me for your last child.

Select one only.

1 ❍ Excellent
2 ❍ Very good
3 ❍ Good
4 ❍ Fair
5 ❍ Poor
d ❍ DON'T KNOW
r ❍ REFUSED

F6. About how many hours a day, on average, is your child in the same room or vehicle with someone who is smoking?

PROBE: Please tell me for your last child.

Select one only.

|___|___|**HOURS PER DAY (ENTER 1 – 24 HOURS)**

0 ❍ Child is never in a room or vehicle with someone who is smoking

1 ❍ Child spends less than one hour per day in a room or vehicle with someone who is smoking

d ❍ DON'T KNOW

r ❍ REFUSED

F7 When your child rides in a car, truck, or van, how often does he or she ride in an infant car seat? Would you say always, often, sometimes, rarely, or never?

PROBE: Please tell me for your last child.

Select one only.

1 ❍ Always

2 ❍ Often

3 ❍ Sometimes

4 ❍ Rarely

5 ❍ Never

6 ❍ NOT APPLICABLE, CHILD NEVER RIDES IN A CAR

d ❍ DON'T KNOW

r ❍ REFUSED

F8. In which position [IF LAST CHILD >= 1 YEAR OLD: did you most often lay your child down to sleep during the first year?]

[IF LAST CHILD < 1 YEAR OLD: do you most often lay your child down to sleep?] [Was/Is] it on the child's side, back, or stomach?

PROBE: Please tell me for your last child.

Select one only.

1 ❍ On child's side

2 ❍ On child's back

3 ❍ On child's stomach

d ❍ DON'T KNOW

r ❍ REFUSED

F9. How often [IF LAST CHILD >= 1 YEAR OLD: did your child sleep in the same bed with you or anyone else during the first year?]

[[IF LAST CHILD < 1 YEAR OLD: does your child sleep in the same bed with you or anyone else?] Would you say always, often, sometimes, rarely, or never?

PROBE: Please tell me for your last child.

Select one only.

1 ❍ Always
2 ❍ Often
3 ❍ Sometimes
4 ❍ Rarely
5 ❍ Never
d ❍ DON'T KNOW
r ❍ REFUSED

F10. Did your partner attend classes and appointments with you during your pregnancy? Was it all of the time, some of the time, or none of the time?

PROBE: Please tell me for your last child.

Select one only.

1 ❍ All the time
2 ❍ Some of the time
3 ❍ None of the time
d ❍ DON'T KNOW
r ❍ REFUSED

F11. Did any family members attend classes and appointments with you during your last pregnancy? Was it all of the time, some of the time, or none of the time?

Select one only.

1 ❍ All the time
2 ❍ Some of the time
3 ❍ None of the time
d ❍ DON'T KNOW
r ❍ REFUSED

F12a. During the past week, how many days did <u>you or your husband/partner/child's father</u> read to your child? Reading stories includes books with words or pictures but not books read by an audio tape, record, CD, or computer.

PROBE: Please tell me for your last child.

|__| NUMBER OF DAYS (0-7) [IF R SAYS EVERYDAY, enter 7]
d ❍ DON'T KNOW
r ❍ REFUSED

F12b. During the past week, how many days did <u>you or your husband/partner/child's father</u> tell stories or sing songs to your child?

PROBE: Please tell me for your last child.

|__| NUMBER OF DAYS (0-7) [IF R SAYS EVERYDAY, enter 7]
d ❍ DON'T KNOW
r ❍ REFUSED

F12c. During the past week, how many days did <u>you or your husband/partner/child's father</u> take your child on any kind of outing, such as to the park, library, zoo, shopping, church, restaurants, or family gatherings?

PROBE: Please tell me for your last child.

|__| NUMBER OF DAYS (0-7) [IF R SAYS EVERYDAY, enter 7]
d ❍ DON'T KNOW
r ❍ REFUSED

F13a. During the past week, how many days did <u>other family member(s)</u> read to your child?

PROBE: Please tell me for your last child.

PROBE: Reading stories includes books with words or pictures but not books read by an audio tape, record, CD, or computer.

|__| NUMBER OF DAYS (0-7)
d ❍ DON'T KNOW
r ❍ REFUSED

F13b. During the past week, how many days did <u>other family member(s)</u> tell stories or sing songs to your child?

PROBE: Please tell me for your last child.

|__| NUMBER OF DAYS (0-7)
d ❍ DON'T KNOW
r ❍ REFUSED

F13c. During the past week, how many days did <u>other family member(s)</u> take your child on any kind of outing, such as to the park, library, zoo, shopping, church, restaurants, or family gatherings?

PROBE: Please tell me for your last child.

|__| NUMBER OF DAYS (0-7)
d ❍ DON'T KNOW
r ❍ REFUSED

F14. During your child's last checkup, did you complete a form asking about your child's development, communication or social behavior?

PROBE: Please tell me for your last child.

Select one only.

1 ❍ Yes
0 ❍ No
d ❍ DON'T KNOW
r ❍ REFUSED

SELECT ONE RESPONSE PER ROW

How concerned are you about …	Not concerned	A little concerned	Very concerned	DON'T KNOW	REFUSED
F15. How your child talks, makes speech sounds, or understands what you say? Would you say you are not concerned at all, a little concerned or very concerned?	1 ❍	2 ❍	3 ❍	d ❍	r ❍
F16. How your child uses his or her arms or legs? Would you say you are not concerned at all, a little concerned or very concerned?	1 ❍	2 ❍	3 ❍	d ❍	r ❍
F17. How your child uses his or her hands or fingers to do things? Would you say you are not concerned at all, a little concerned or very concerned?	1 ❍	2 ❍	3 ❍	d ❍	r ❍
F18. How your child is learning to do things for himself or herself? Would you say you are not concerned at all, a little concerned or very concerned?	1 ❍	2 ❍	3 ❍	d ❍	r ❍
F19. How your child behaves or gets along with others? Would you say you are not concerned at all, a little concerned or very concerned?	1 ❍	2 ❍	3 ❍	d ❍	r ❍

G. Health Education

SELECT ONE RESPONSE PER ROW

Did you ever get information about…	Ever received information? Yes, from Healthy Start only	Yes, from another source only	Yes, from both	No	DON'T KNOW	REFUSED
G1. Taking folic acid or a multivitamin during pregnancy? IF YES: Was it from Healthy Start, another source, or both? *Healthy Pregnancy & Parenting, #E7 Modified*	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G2. Eating healthy food during pregnancy? IF YES: Was it from Healthy Start, another source, or both? *Healthy Pregnancy & Parenting, #E7 modified*	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G3. How much weight to gain during pregnancy? IF YES: Was it from Healthy Start, another source, or both? *Healthy Pregnancy & Parenting, #E7 modified*	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍

SELECT ONE RESPONSE PER ROW

Did you ever get information about…	Ever received information?					
	Yes, from Healthy Start only	Yes, from another source only	Yes, from both	No	DON'T KNOW	REFUSED
G4. *Healthy Pregnancy & Parenting, #E7 modified* **Health risks during pregnancy, such as high blood pressure and preterm birth?** **IF YES: Was it from Healthy Start,another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G5. *Healthy Pregnancy & Parenting, #E7 modified* **Using a seatbelt during pregnancy?** **IF YES: Was it from Healthy Start, another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G6. *Healthy Pregnancy & Parenting, #E7 modified* **Smoking during pregnancy?** **IF YES: Was it from Healthy Start, another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G7. *Healthy Pregnancy & Parenting, #E7 modified* **Alcohol or drug use, such as marijuana, cocaine, or crack, during pregnancy?** **IF YES: Was it from Healthy Start, another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G8. *Healthy Pregnancy & Parenting, #E7 modified* **Being depressed after giving birth or getting the baby blues?** **IF YES: Was it from Healthy Start, another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G9. *Healthy Pregnancy & Parenting, #E7 modified* **Parenting?** **IF YES: Was it from Healthy Start, another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G10. *Healthy Pregnancy & Parenting, #E7 modified* **How to install and use an infant car seat?** **IF YES: Was it from Healthy Start, or another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G11. *Healthy Pregnancy & Parenting, #E7 modified* **Safe sleep positions for infants?** **IF YES: Was it from Healthy Start, another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G12. *Healthy Pregnancy & Parenting, #E7 modified* **Family planning or birth control?** **IF YES: Was it from Healthy Start, another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G13. *Healthy Pregnancy & Parenting, #E7 modified* **Did you ever get information about what to do if you have or someone you know has a partner that hurts them physically?** **IF YES: Was it from Healthy Start, another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍

SELECT ONE RESPONSE PER ROW

Did you ever get information about…	Ever received information?					
	Yes, from Healthy Start only	Yes, from another source only	Yes, from both	No	DON'T KNOW	REFUSED
G14. *Healthy Pregnancy & Parenting, #E7 modified* **Where to get support if you are feeling depressed? IF YES: Was it from Healthy Start or another source?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G15. *Healthy Pregnancy & Parenting, #E7 modified* **How to manage stress? IF YES: Was it from Healthy Start, another sourcE, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G16. *Healthy Pregnancy & Parenting, #E7 modified* **Getting vaccinations, such as a flu shot? IF YES: Was it from Healthy Start, another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G17. *Health Pregnancy & Parenting, #E7 modified* **How to keep a healthy weight such as through diet and exercise? IF YES: Was it from Healthy Start, another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G18. *Healthy Pregnancy & Parenting, #E7 modified* **Keeping your teeth healthy? IF YES: Was it from Healthy Start, another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G19. *Healthy Pregnancy & Parenting, #E7 modified* **Sexually transmitted infections or STIs? IF YES: Was it from Healthy Start, another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G20. *Healthy Pregnancy & Parenting, #E7 modified* **How to find out if you are eligible for Medicaid? IF YES: Was it from Healthy Start, another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍
G21. *Healthy Pregnancy & Parenting, #E7 modified* **How to find out if you are eligible for WIC? IF YES: Was it from Healthy Start, another source, or both?**	1 ❍	2 ❍	3 ❍	4 ❍	d ❍	r ❍

H. Health Service Utilization

Next, I would like to ask you about the types of health services you use.

H1. Is there a place that you usually go when you are sick?

Select one only.

1 ❍ Yes
0 ❍ No **SKIP TO H2**
d ❍ DON'T KNOW **SKIP TO H2**
r ❍ REFUSED **SKIP TO H2**

H1a. What type of place do you usually go to when you are sick?

Select one only.

SLAITS #K4Q01 modified

1 ❍ Clinic or health center
2 ❍ Doctor's office of an HMO
3 ❍ Hospital emergency room
4 ❍ Outpatient department or urgent care
d ❍ DON'T KNOW
r ❍ REFUSED

H2. Is there a place that you usually go for a checkup?

Select one only.

1 ❍ Yes
0 ❍ No **SKIP TO H3**
d ❍ DON'T KNOW **SKIP TO H3**
r ❍ REFUSED **SKIP TO H3**

H2a. What type of place do you usually go for a checkup?

Select one only.

1 ❍ Clinic or health center
2 ❍ Doctor's office of an HMO
3 ❍ Hospital emergency room
4 ❍ Outpatient department or urgent care
d ❍ DON'T KNOW
r ❍ REFUSED

H3. A personal doctor or nurse is a health professional who knows you well and is familiar with your health history. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician's assistant. Do you have one or more persons you think of as your personal doctor or nurse?

IF RESPONDENT SAYS YES, ASK: Is there one person or more than one person?

Select one only.

1 ❍ Yes, one person
2 ❍ Yes, more than one person
0 ❍ No
d ❍ DON'T KNOW
r ❍ REFUSED

H4. During the past 12 months, did you see a doctor, nurse, or other health care worker for preventive medical care, such as a physical or well visit checkup?

Select one only.

1 ❍ Yes
0 ❍ No **SKIP TO H5**
d ❍ DON'T KNOW **SKIP TO H5**
r ❍ REFUSED **SKIP TO H5**

H4a. During the past 12 months, how many times did you see a doctor, nurse, or other health care worker for preventive medical care such as a physical exam or well visit checkup?

|___|___| TIMES
d ❍ DON'T KNOW
r ❍ REFUSED

IF E1A OR E2A = 1 OR MORE (CLIENT HAD LIVE BIRTH), CONTINUE WITH H5. OTHERWISE, SKIP TO H10.

H5. Is there a place that you usually go when your child is sick?

PROBE: Please tell me for your last child.

Select one only.

1 ❍ Yes
0 ❍ No **SKIP TO H6**

d ❍ DON'T KNOW **SKIP TO H6**
r ❍ REFUSED **SKIP TO H6**

H5a. **What type of place do you usually go to when your child is sick?**

PROBE: Please tell me for your last child.

Select one only.

1 ❍ Clinic or health center
2 ❍ Doctor's office of HMO
3 ❍ Hospital emergency room
4 ❍ Outpatient department or urgent care
d ❍ DON'T KNOW
r ❍ REFUSED

H6. **Is there a place that you usually go for health advice or routine preventive care for your child?**

PROBE: Please tell me for your last child.

Select one only.

1 ❍ Yes
0 ❍ No **SKIP TO H7**
d ❍ DON'T KNOW **SKIP TO H7**
r ❍ REFUSED **SKIP TO H7**

H6a. **What type of place do you usually go for health advice or routine preventive care for your child?**

PROBE: Please tell me for your last child.

Select one only.

1 ❍ Clinic of health center
2 ❍ Doctor's office of HMO
3 ❍ Hospital emergency room
4 ❍ Outpatient department or urgent care
d ❍ DON'T KNOW
r ❍ REFUSED

H7. **A personal doctor or nurse for your child is a health professional who knows your child well and is familiar with your child's health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician's assistant. Do you have one or more persons you think of as your child's personal doctor or nurse?**
IF RESPONDENT SAYS YES, ASK: Is there one person or more than one person?

SL/ ITS #K

Select one only.

1 ❍ Yes, one person
2 ❍ Yes, more than one person
0 ❍ No
d ❍ DON'T KNOW

r ❍ REFUSED

H8. **During the past 12 months, did your child see a doctor, nurse, or other health care worker for preventive medical care, such as a physical or well visit checkup?**

PROBE: Please tell me for your last child.

Select one only.

1 ❍ Yes
0 ❍ No **SKIP TO H9**
d ❍ DON'T KNOW **SKIP TO H9**
r ❍ REFUSED **SKIP TO H9**

H8a. **During the past 12 months, how many times did your child see a doctor, nurse, or other health care worker for preventive medical care such as a physical exam or well visit checkup?**

PROBE: Please tell me for your last child.

|__|__| TIMES
d ❍ DON'T KNOW
r ❍ REFUSED

H9. **Has your child been given any vaccines or baby shots yet? Please do not include the shots given when your baby was born.**

Select one only.

1 ❍ Yes
0 ❍ No **SKIP TO H10**
d ❍ DON'T KNOW **SKIP TO H10**
r ❍ REFUSED **SKIP TO H10**

H9a. **How old was your child the last time he or she got vaccines or shots?**

|__|__| WEEKS OR
|__|__| MONTHS
d ❍ DON'T KNOW
r ❍ REFUSED

H10. What are you using to keep from getting pregnant?

Select all that apply

PRAMS Standard Phase 6, #E3 modified

1 ☐ Tubes tied or closed (female sterilization)
2 ☐ Vasectomy (male sterilization)
3 ☐ Pill
4 ☐ Condoms
5 ☐ Injection once every three months (Depo-Provera®)
6 ☐ Contraceptive implant (Implanon®)
7 ☐ Contraceptive patch (OrthoEvra®)
8 ☐ Diaphragm, cervical cap, or sponge
9 ☐ Cervical vaginal ring (NuvaRing®)
10 ☐ IUD (including Mirena®)
11 ☐ Rhythm method or natural family planning

I. Client's Perspective on Her Community

I1. Now I am going to ask you a few questions about your neighborhood. Please tell me if you agree or disagree with each of these statements.

SELECT ONE RESPONSE PER ROW.

	Agree	Disagree	DON'T KNOW	REFUSED
a. People in this neighborhood help each other out.	1 ❍	2 ❍	d ❍	r ❍
b. We watch out for each other's children in this neighborhood.	1 ❍	2 ❍	d ❍	r ❍
c. There are people I can count on in this neighborhood.	1 ❍	2 ❍	d ❍	r ❍
d. If my child were outside playing and got hurt or scared, there are adults nearby who I trust to help my child.	1 ❍	2 ❍	d ❍	r ❍

I2. How often do you feel safe in your community? Would you say never, sometimes, usually, or always?

Select one only.

1 ❍ Never
2 ❍ Sometimes
3 ❍ Usually
4 ❍ Always
d ❍ DON'T KNOW
r ❍ REFUSED

I3. How often do you get together or talk with friends or neighbors? Would you say daily, weekly, monthly, less than monthly, or never?

Select one only.

1 ❍ Daily
2 ❍ Weekly
3 ❍ Monthly
4 ❍ Less often than monthly
5 ❍ Never
d ❍ DON'T KNOW
r ❍ REFUSED

I4. **How often do you participate in school, community, or neighborhood activities? Would you say weekly, monthly, several times a year, about once a year, less than once a year or never?**

SHADAC modified

Select one only.

1 ❍ Weekly
2 ❍ Monthly
3 ❍ Several times a year
4 ❍ About once a year
5 ❍ Less than once a year
6 ❍ Never
d ❍ DON'T KNOW
r ❍ REFUSED

I5. The Healthy Start Community Action, or CAN is a group of people representing different organizations and stakeholders in the community that are trying to make it better for women, children, and their families. Are you a member of the CAN?

Select one only.

1 ❍ Yes
0 ❍ No
d ❍ DON'T KNOW
r ❍ REFUSED

J. Healthy Start Services (ADMINISTRATIVE USE ONLY)

J1. HEALTHY START SERVICES:

Select all types of services the client received during the fiscal year based on Healthy Start records, include services received by the client's child, the child's father, or the client's partner.

	SELECT ONE RESPONSE PER ROW	
	YES	NO
a. Case management services	1 ❍	0 ❍
b. Developmental screenings for child	1 ❍	0 ❍
c. Enabling services (transportation, child care etc.)	1 ❍	0 ❍
d. Father/partner involvement promotion	1 ❍	0 ❍
e. Health education and promotion	1 ❍	0 ❍
f. Health insurance outreach and enrollment services	1 ❍	0 ❍
g. Linkage to medical home providers	1 ❍	0 ❍
h. Linkage to mental and behavioral health	1 ❍	0 ❍
i. Parenting education	1 ❍	0 ❍
j. Patient navigation	1 ❍	0 ❍
k. Reproductive life planning	1 ❍	0 ❍
l. Services that address toxic stress and adverse childhood experiences (ACE)	1 ❍	0 ❍
m. Other services	1 ❍	0 ❍

IF J1a = 1 (Yes), ANSWER QUESTION J2. OTHERWISE, SKIP TO QUESTION J3.

J2. CASE MANAGEMENT SERVICES:

Select all types of case management services the client received during the fiscal year based on Healthy Start records; do not include services received by the client's child, the child's father, the client's partner or any other family member.

	SELECT ONE RESPONSE PER ROW	
	YES	NO
a. Care coordination for health services	1 ❍	0 ❍
b. Coordination of social services	1 ❍	0 ❍
c. Counseling and guidance	1 ❍	0 ❍
d. Home visiting	1 ❍	0 ❍
e. Referrals	1 ❍	0 ❍

J3. SCREENINGS:

Select all types of screenings and assessments the client received during the fiscal year based on Healthy Start records;. do not include screenings received by the client's child, the child's father, the client's partner or any other family member.

	SELECT ONE RESPONSE PER ROW	
	YES	NO
a. Alcohol use	1 ❍	0 ❍
b. Anemia	1 ❍	0 ❍
c. Asthma	1 ❍	0 ❍
d. Depression	1 ❍	0 ❍
e. Diabetes	1 ❍	0 ❍
f. Domestic/ intimate partner violence	1 ❍	0 ❍
g. Healthy weight/ BMI	1 ❍	0 ❍
h. HIV	1 ❍	0 ❍
i. Hypertension	1 ❍	0 ❍
j. Homelessness/ inadequate shelter	1 ❍	0 ❍
k. Social emotional support	1 ❍	0 ❍
l. Maternal infant attachment parenting deficit	1 ❍	0 ❍
m. Nutrition/ Physical activity	1 ❍	0 ❍
n. Physical disability	1 ❍	0 ❍
o. Sickle cell disease	1 ❍	0 ❍
p. Smoking/ Exposure to second hand smoke	1 ❍	0 ❍
q. Substance abuse	1 ❍	0 ❍
r. STIs other than HIV	1 ❍	0 ❍
s. Other medical risks	1 ❍	0 ❍
t. Other mental health risks	1 ❍	0 ❍
u. Other screening or assessment not listed above:_____	1 ❍	0 ❍

J4. REFERRALS:

Select all types of referrals the client received <u>during the fiscal year</u> based on Healthy Start records; <u>do not include</u> referrals received by the client's child, the child's father, the client's partner or any other family member.

	SELECT ONE RESPONSE PER ROW	
	YES	NO
a. Alcohol counseling	1 ❍	0 ❍
b. Breastfeeding support	1 ❍	0 ❍
c. Child care	1 ❍	0 ❍
d. Chronic disease management services	1 ❍	0 ❍
e. Education services	1 ❍	0 ❍
f. Employment services	1 ❍	0 ❍
g. HIV/AIDS services	1 ❍	0 ❍
h. Housing/ heating	1 ❍	0 ❍
i. Intimate partner violence counseling and support	1 ❍	0 ❍
j. Medical home/care- infant	1 ❍	0 ❍
k. Medical home/care – woman	1 ❍	0 ❍
l. Mental/behavioral health	1 ❍	0 ❍
m. Nutrition and physical activity services	1 ❍	0 ❍
n. Parenting support services	1 ❍	0 ❍
o. Sexual and reproductive health services	1 ❍	0 ❍
p. Transportation	1 ❍	0 ❍
q. WIC/ Food assistance	1 ❍	0 ❍
r. Other services not listed: _____	1 ❍	0 ❍

Thank you for taking the time to complete this form with me. The information you provided will help us improve the services for women, children, and their families in your community.