

# Healthy Start Preconception Screening Tool | August 2016

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OMB #: 0915-0338  
Expiration Date: XX/XX/XXXX

Name: \_\_\_\_\_

Completed by: \_\_\_\_\_ Date of Administration: \_\_\_\_\_

This tool should be completed for women in the preconception period. This phase refers to the time period before becoming pregnant. During this phase, Healthy Start works with women (and sometimes partners) to improve their health, prepare their bodies for pregnancy if they desire it, and promote family planning.

Some key aims for HS grantees during this phase:

- Optimize women's health, behaviors, and knowledge before pregnancy
  - Enhance access to and quality of care for women before and between pregnancies
  - Facilitate reproductive life planning (planning pregnancy, contraception, optimum birth spacing)
  - Promote education, screening, referral, and treatment for women with high-risk conditions
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*The questions and answer choices were selected based on the available evidence about factors that may impact a woman's health or pregnancy outcomes. The information provided by the participant through this screening tool will help Healthy Start identify each participant's unique needs and ensure that she is connected to the appropriate support services.*

*Please read the questions to the participant. Do not read the responses to the participant unless the directions indicate that the answers should be read out loud to the participant.*

***Please read the following statement to the participant: Thank you for taking time to complete this interview. Any information you provide will be kept confidential to the extent allowed by law. You do not have to answer any question you do not want to, and you can end the interview at any time.***

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## Social Determinants of Health

Let's start off with some background information.

**1. Are you currently married or living with a partner, separated, divorced, widowed, or were you never married?**

Select one only.

- |  |  |
|--|--|
| <input type="radio"/> Married or living with a partner | <input type="radio"/> Widowed            |
| <input type="radio"/> Separated                        | <input type="radio"/> Never married      |
| <input type="radio"/> Divorced                         | <input type="radio"/> Declined to answer |

**2. Are you currently...**

**STAFF: Please read responses to participant.**

Select one only.

- |  |  |
|--|--|
| <input type="radio"/> Employed for wages               | <input type="radio"/> A Student          |
| <input type="radio"/> Self-employed                    | <input type="radio"/> Retired            |
| <input type="radio"/> Out of work for 1 year or more   | <input type="radio"/> Unable to work     |
| <input type="radio"/> Out of work for less than 1 year | <b>DO NOT READ OUT LOUD</b>              |
| <input type="radio"/> A Homemaker                      | <input type="radio"/> Declined to answer |

**3. 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. All information will be kept private and will not affect any services you are now getting.**

Select one only.

- |  |  |
|--|--|
| <input type="radio"/> Less than \$10,000             | <input type="radio"/> \$35,000 to less than \$50,000 |
| <input type="radio"/> \$10,000 to less than \$15,000 | <input type="radio"/> \$50,000 or more               |
| <input type="radio"/> \$15,000 to less than \$20,000 | <input type="radio"/> Don't know                     |
| <input type="radio"/> \$20,000 to less than \$25,000 | <input type="radio"/> Declined to answer             |
| <input type="radio"/> \$25,000 to less than \$35,000 |  |

**4. How many people are supported by this income?**

**STAFF: Enter number of people.**

\_\_\_\_\_ Adults age 18 or older  
\_\_\_\_\_ Children age 18 or younger

- Don't know  
 Declined to answer

*The next question is about whether you were able to afford the food you need.*

**5. Which of these statements best describes the food situation in your household IN THE PAST 12 MONTHS? STAFF: Please read responses to participant.**

Select one only.

- € We could always afford to eat good nutritious meals.
- € We could always afford enough to eat but not always the kinds of food we should eat.
- € Sometimes we could not afford enough to eat.
- € Often we could not afford enough to eat.
- € Declined to answer

**6. What is the Zip Code where you live?**

- \_\_\_\_\_
- € Don't Know
  - € Declined to answer

**7. Do you own a place, rent a place, live in public housing, stay with a family member, or are you homeless?**

Select one only.

- € Owns or shares own home, condominium or apartment (Go to question 8)
- € Rents or shares own home or apartment (Go to question 7.1)
- € Lives in public housing (receives rental assistance, such as Section 8) (Go to question 7.1)
- € Lives with parent or family member (Go to question 7.1)
- € Homeless (Go to question 7.2)
- € Some other arrangement (Please specify): \_\_\_\_\_ (Go to question 7.1)
- € Declined to answer (Go to question 8)

**7.1 Is this place a regular place to stay? By "a regular place to stay" I am referring to a house, apartment, room, or other housing where you could stay 30 days in a row or more in the same place.**

Select one only.

- € Yes (Go to question 8)
- € No (Go to question 8)
- € Don't know (Go to question 8)
- € Declined to answer (Go to question 8)

**7.2. Do you share housing with someone, live in an emergency or transition shelter, or have some other living arrangement?**

Select one only.

- Homeless and shares housing with someone
- Lives in an emergency or transition shelter
- Some other arrangement: \_\_\_\_\_
- Declined to answer

**8. Do you have any housing concerns?**

Select one only.

- Yes (Go to question 8.1)
- No (Go to question 9)
- Don't know (Go to question 9)
- Declined to answer (Go to question 9)

**8.1. What issues concern you about your housing situation?**

Select all that apply.

- |  |  |
|--|--|
| <input type="checkbox"/> Received an eviction notice   | <input type="checkbox"/> Friend or family member being evicted or threatened with eviction |
| <input type="checkbox"/> Non-payment of rent or past due rent  | <input type="checkbox"/> Threat of abuse by partner, family member, or other               |
| <input type="checkbox"/> Unable to pay future rent because lost housing subsidy, job, or other income source | <input type="checkbox"/> Being discharged or service is being terminated                   |
| <input type="checkbox"/> Non-payment of utilities or utility shut-off  | <input type="checkbox"/> Personal conflict with others                                     |
| <input type="checkbox"/> Housekeeping concerns (failure to maintain cleanliness of the unit)                 | <input type="checkbox"/> Other health or safety concerns                                   |
| <input type="checkbox"/> Housing is or will be condemned   | <input type="checkbox"/> Other lease violation(s) (please describe): _____                 |
|  | <input type="checkbox"/> Other (please describe): _____                                    |
|  | <input type="checkbox"/> Don't know  |
|  | <input type="checkbox"/> Declined to answer  |

**9. I am going to read a list of services. Please tell me if you are receiving the service, if you have applied for the service and are waiting to find out if you will receive services, if you need services, or if you don't need services. I want to remind you that I ask these questions so we can provide the best services for your family.**

STAFF: Please read each of the following services to participant and enter an answer for each service.

	Receiving	Have applied for	Need	Do not need	Not applicable	Declined to answer
Childcare voucher						
Emergency Aid to the Elderly, Disabled, and Children (EAEDC)						
Food stamps/SNAP						
Heating assistance						
Immigration services						
Legal services						
Public housing						
Section 8 Voucher						
Social Security Disability Insurance (SSDI)						
Social Security Income (SSI)						
Transitional Aid to Families with Dependent Children (TAFDC)						
Temporary Assistance to Needy Families (TANF)						
Tribal Housing						
Utility Assistance						
Nutrition Supplemental Program for Women Infants and Children (WIC)						
Other (please specify)						

FOLLOW UP	
<p><b>Provided information/education about:</b></p> <ul style="list-style-type: none"><li>€ Childcare voucher</li><li>€ Emergency Aid to the Elderly, Disabled, and Children (EAEDC)</li><li>€ Food stamps/SNAP</li><li>€ Heating assistance</li><li>€ Immigration services</li><li>€ Legal services</li><li>€ Public housing</li><li>€ Section 8 Voucher</li><li>€ Social Security Disability Insurance (SSDI)</li><li>€ Social Security Income (SSI)</li><li>€ Transitional Aid to Families with Dependent Children (TAFDC)</li><li>€ Temporary Assistance to Needy Families (TANF)</li><li>€ Tribal Housing</li><li>€ Utility Assistance</li><li>€ Nutrition Supplemental Program for Women Infants and Children (WIC)</li><li>€ Other (please specify)</li></ul> <p>Date _____</p>	<p><b>Referral made for:</b></p> <ul style="list-style-type: none"><li>€ Childcare voucher</li><li>€ Emergency Aid to the Elderly, Disabled, and Children (EAEDC)</li><li>€ Food stamps/SNAP</li><li>€ Heating assistance</li><li>€ Immigration services</li><li>€ Legal services</li><li>€ Public housing</li><li>€ Section 8 Voucher</li><li>€ Social Security Disability Insurance (SSDI)</li><li>€ Social Security Income (SSI)</li><li>€ Transitional Aid to Families with Dependent Children (TAFDC)</li><li>€ Temporary Assistance to Needy Families (TANF)</li><li>€ Tribal Housing</li><li>€ Utility Assistance</li><li>€ Nutrition Supplemental Program for Women Infants and Children (WIC)</li><li>€ Other (please specify)</li></ul> <p>Date _____</p>

## Neighborhood and Community

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

STAFF: Please read each of the following statements to participant and enter an answer for each statement.

Q#	Statement	Agree	Disagree	Don't know	Declined to answer
10.1	People in this neighborhood or community help each other out				
10.2	We watch out for each other's children in this neighborhood or community				

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

Select one only.

- |                                 |  |
|---------------------------------|--|
| <input type="radio"/> Never     | <input type="radio"/> Always             |
| <input type="radio"/> Sometimes | <input type="radio"/> Declined to answer |
| <input type="radio"/> Usually   |  |

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

Select one only.

- |  |   |
|--|---|
| <input type="radio"/> Daily              | <input type="radio"/> Less than once a year |
| <input type="radio"/> Weekly             | <input type="radio"/> Never                 |
| <input type="radio"/> Monthly            | <input type="radio"/> Declined to answer    |
| <input type="radio"/> A few times a year |   |

**13. How often do you get together or talk with family, friends or neighbors? Would you say daily, weekly, monthly, a few times a year, less than once a year or never?**

Select one only.

- |  |   |
|--|---|
| <input type="radio"/> Daily              | <input type="radio"/> Less than once a year |
| <input type="radio"/> Weekly             | <input type="radio"/> Never                 |
| <input type="radio"/> Monthly            | <input type="radio"/> Declined to answer    |
| <input type="radio"/> A few times a year |   |

## Medical Home / Access to Care/Health Insurance

**14. 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?**

Select one only

- Yes, one person
- Yes, more than one person
- No (Go to question 16)
- Don't know (Go to question 16)
- Declined to answer (Go to question 16)

**15. Is there a place that you USUALLY go for care when you are sick or need advice about your health?**

Select one only

- Yes (Go to question 15.1)
- No (Go to question 16)
- There is more than one place (go to question 16.1)
- Don't know (Go to question 17)
- Declined to answer (Go to question 17)

**15.1. What kind of place do you go to most often when you are sick or you need advice about your health? Is it a doctor's office, emergency room, hospital outpatient department, clinic or some other place?**

Select one only

- Doctor's Office
- Hospital Emergency Room
- Hospital Outpatient Department
- Clinic or Health Center
- Retail Store Clinic or "Minute Clinic"
- School (Nurse's Office, Athletic Trainer's Office)
- Some other place



16. ~~Please~~ **Describe in what kind of health insurance you have:** ~~TRICARE or other military health care~~
- Select all that apply:
- Insurance purchased through the job of my husband, partner or parents.
  - Insurance purchased directly from an insurance company
  - Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability
  - TRICARE or other military health care
  - Indian Health Service
  - Other, specify: \_\_\_\_\_
  - No insurance
  - Don't know
  - Declined to answer

**17. 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

- Yes
- No
- Don't know
- Declined to Answer

## Health and Health History

**18. In general, would you say that your overall health is excellent, very good, good, fair, or poor?**

Select one only.

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know
- Declined to answer

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

Select one only.

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know
- Declined to answer

## 20.1 How tall are you without shoes?

Please enter height in feet and inches.

\_\_\_\_\_ Feet \_\_\_\_\_ Inches

€ Don't Know

€ Declined to answer

## 20.2 How much do you weigh?

Please enter weight in pounds.

\_\_\_\_\_ Pounds

€ Declined to answer

€ Don't Know

## 21. Has a healthcare provider ever told you that you have any of the following medical conditions?

**STAFF: Read each condition to participant. Select one response only for each question. If participant has a condition, please ask if they currently have this condition.**

### Asthma (breathing problems/wheezing)

€ Yes

€ Don't know

€ No

€ Declined to answer

If **yes**, ask: Is this something you have currently?

€ Yes

€ Don't know

€ No

€ Declined to answer

### Autoimmune disease [Lupus (SLE), Rheumatoid Arthritis (RA), etc.]

€ Yes

€ Don't know

€ No

€ Declined to answer

If **yes**, ask: Is this something you have currently?

€ Yes

€ Don't know

€ No

€ Declined to answer

### Cancer

Yes

No

If **yes**, ask: Is this something you have currently?

Yes

No

Don't know

Declined to answer

Don't know

Declined to answer

## Cardiovascular disease (heart problems)

Yes

No

If **yes**, ask: Is this something you have currently?

Yes

No

Don't know

Declined to answer

Don't know

Declined to answer

## Depression or other mental health conditions (anxiety, bipolar)

Yes

No

If **yes**, ask: Is this something you have currently?

Yes

No

Don't know

Declined to answer

Don't know

Declined to answer

## Diabetes (high blood sugar)

Yes

No

If **yes**, ask: Is this something you have currently?

Yes

No

Don't know

Declined to answer

Don't know

Declined to answer

## Eating disorders (anorexia/bulimia)

Yes

No

If **yes**, ask: Is this something you have currently?

Yes

No

Don't know

Declined to answer

Don't know

Declined to answer

## High blood pressure

Yes

No

Don't know

Declined to answer

If **yes**, ask: Is this something you have currently?

Yes

No

Don't know

Declined to answer

## Iron Deficient Anemia

Yes

No

Don't know

Declined to answer

If **yes**, ask: Is this something you have currently?

Yes

No

Don't know

Declined to answer

## PKU (phenylketonuria)

Yes

No

Don't know

Declined to answer

If **yes**, ask: Is this something you have currently?

Yes

No

Don't know

Declined to answer

## Renal disease (kidney problems)

Yes

No

Don't know

Declined to answer

If **yes**, ask: Is this something you have currently?

Yes

No

Don't know

Declined to answer

### Seizure disorders (Epilepsy)

Yes

No

Don't know

Declined to answer

If **yes**, ask: Is this something you have currently?

Yes

No

Don't know

Declined to answer

### Sickle Cell

Yes

No

Don't know

Declined to answer

If **yes**, ask: Is this something you have currently?

Yes

No

Don't know

Declined to answer

### Thrombophilia (blood clots)

Yes

No

Don't know

Declined to answer

If **yes**, ask: Is this something you have currently?

Yes

No

Don't know

Declined to answer

### Thyroid disease - hypo/hyper (overactive or underactive thyroid)

Yes

No

Don't know

Declined to answer

If **yes**, ask: Is this something you have currently?

Yes

No

Don't know

Declined to answer

### Other \_\_\_\_\_

If **yes**, ask: Is this something you have currently?

Yes

No

Don't know

Declined to answer

**STAFF: If participant currently has any of the above conditions, go to question 22.**

**If participant does not currently have any of the above conditions, go to question 23.**

**22. Please tell me which condition or conditions you were seen for by a healthcare provider in the past 6 months.**

Select all that apply.

- € Asthma (Breathing problems/wheezing)
- € Autoimmune disease (such as lupus (SLE), Rheumatoid Arthritis (RA))
- € Cancer
- € Cardiovascular disease (Heart problems)
- € Depression or other mental health conditions (anxiety, bipolar)
- € Diabetes (High blood sugar)
- € Eating disorders (Anorexia/bulimia)
- € High Blood Pressure
- € PKU (phenylketonuria)
- € Renal disease (Kidney problems)
- € Seizure disorders (Epilepsy)
- € Sickle Cell
- € Thrombophilia (Blood Clots)
- € Thyroid disease—(Hypo/hyper—overactive or underactive thyroid)

**23. Are you currently having any pain?**

Select one only

- € Yes
- € No
- € Declined to answer

**24. Are you taking any of the following medications? We are asking about these medications because they are known to have an impact on the fetus.**

**STAFF: ask participant specifically about each medication below, and enter a response for each medication.**

Are you taking any:	Yes	No	Don't know	Declined to answer
Pain medications (such as morphine,				

codeine, oxycodone, Vicodin, or methadone)				
Blood Thinners (such as Coumadin, heparin, or Lovenox)				
Male Hormones (such as testosterone)				
Antibiotics (such as tetracycline, doxycycline, Flagyl or streptomycin, trimethoprim, Bactrim, Septra)				
Seizure or Epilepsy medications (such as valproate, Dilantin or Depakote)				
Acne medications (such as Accutane, Retin-A)				
High Blood Pressure medications (ace inhibitors such as Capoten, Vasotec, Lotensin)				
High Cholesterol medications (statins, such as Lipitor, Pravachol, Zocor, Mevacor)				
Antidepressants (such as lithium, Paxil)				

**24.1. Does your provider know all the medications that you are taking? Please tell me for prescribed as well as over the counter medications.**

Select only one.

- Yes
- No
- Not taking any medications
- Don't know
- Declined to answer

**25. During the past month, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?**

Select one only

- I did not take a multivitamin, prenatal vitamin or folic acid vitamin at all
- 1 to 3 times a week
- 4 to 6 times a week
- Every day of the week
- Don't Know
- Declined to answer

**26. 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?**

Select one only.

- € Less than six months ago
- € Six months to one year ago
- € More than one year ago

- € Never
- € Don't know
- € Declined to answer

**27. Have you ever received the following vaccines?**

**STAFF: Please read each vaccine type to participant, and enter one response for each vaccine type.**

Q#	Vaccine	Yes	No	Don't know	Declined to answer
27.1	MMR (measles, mumps, rubella) vaccine				
27.1.1	<b>If not</b> , have you been tested for immunity to rubella?				
27.2	Hepatitis B vaccine (3 doses)				
27.3	All 3 shots of the Gardasil (HPV virus) vaccine				
27.4	Have you ever had chicken pox or shingles?				
27.4.1	<b>If not</b> , have you received 2 doses of the varicella vaccine?				
27.5	In the last 10 years, have you received Tdap (tetanus, diphtheria, and pertussis)?				

**28. When was the last time you were tested for sexually transmitted diseases or sexually transmitted infections?**

STAFF: Please read each sexually transmitted disease/infection to participant, and enter one response for each one.

Sexually Transmitted Disease/Infection	Less than 6 months ago	6 months to 1 year ago	More than 1 year ago	Never	Don't know	Declined to answer
Chlamydia						
Gonorrhea						
Herpes Simplex						
HIV						
Syphilis						
Other:						

**29. Have you ever been diagnosed with any of the following infectious diseases?**

STAFF: Please read each infectious disease to participant, and enter one response for each infectious disease.



<b>Infectious Disease</b>	<b>Yes</b>	<b>No</b>	<b>Don't know</b>	<b>Declined to answer</b>
Toxoplasmosis				
Tuberculosis				
Cytomegalovirus				
Hepatitis B or C				
Zika				
Chlamydia				
Gonorrhea				
Herpes Simplex				
HIV				
Syphilis				
Other:				

**30. Thinking back over the past 12 months would you say you used a condom with your partner or partners for sexual intercourse every time, most of the time, about half the time, some of the time, or none of the time?**

Select one only

- |  |  |
|--|--|
| <input type="radio"/> Every time             | <input type="radio"/> None of the time   |
| <input type="radio"/> Most of the time       | <input type="radio"/> Not applicable     |
| <input type="radio"/> About half of the time | <input type="radio"/> Don't know         |
| <input type="radio"/> Some of the time       | <input type="radio"/> Declined to answer |

**31. 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?**

Select one only.

- |  |  |
|--|--|
| <input type="radio"/> Less than six months ago   | <input type="radio"/> Never              |
| <input type="radio"/> Six months to one year ago | <input type="radio"/> Don't know         |
| <input type="radio"/> More than one year ago     | <input type="radio"/> Declined to answer |

**FOLLOW UP**

**Provided information/education about:**

- Keeping a healthy weight such as through diet and exercise
- Importance of vitamins/folic acid
- Getting vaccines
- Getting flu shot
- Travel advisory
- Sexually transmitted infections

- € Keeping teeth healthy
- € Health risks during pregnancy

Date \_\_\_\_\_

**Provided:**

- € Nutritional counseling
- € Immunizations: Please specify \_\_\_\_\_
- € Pain assessment

Date \_\_\_\_\_

**Referred to:**

- € Primary Care Provider
- € Nutritionist
- € Dentist
- € Other: Please specify \_\_\_\_\_

Date \_\_\_\_\_

**Mental Health**

32. Over the past two weeks, how often have you experienced any of the following, would you say never, several days, more than half the days, or nearly every day?

**STAFF: Read each problem to participant, and enter one score for each question.**

Q#	Problem	Not at all	Several Days	More than half the days	Nearly every day	Score
32.1	Little interest or pleasure in doing things	0	1	2	3	
32.2	Feeling down, depressed, or hopeless	0	1	2	3	
	Total Score					

**NOTE:** Enter the number that matches the participant's answer in the last column, and add the

answers for both together to get the final score. If the final score is more than 3, further assessment is needed.

FOLLOW UP
<p>€ Provided information/ education about resources for depression</p> <p>Date _____</p>
<p>€ Provided further assessment using evidence-based tool such as PHQ-9 or Edinburgh Postnatal Depression Screening Tool.</p> <p>Date _____</p>
<p>€ Provided counseling</p> <p>Date _____</p>
<p><b>Referred to:</b></p> <p>€ Mental Health Center</p> <p>€ Primary Care Provider</p> <p>€ Other: Please specify _____</p> <p>Date _____</p>

## Substance Use

*If it's okay with you, I'd like to ask you a few questions that will help me give you better care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use.*

**33. In the past 12 months, how often have you used the following?**

**STAFF: Read substances and answers to participant and enter one response for each substance.**

Substance	Never	Once or Twice Monthly	Weekly	Daily or Almost Daily	Declined to answer
<b>Alcohol</b> (4 or more drinks per day)					
<b>Tobacco Products</b> (including cigarettes, chewing tobacco, snuff, iqmik, or other tobacco products like snus Camel Snus, orbs, e-cigarettes, lozenges, cigars, or hookah)					
<b>Mood-altering Drugs</b> (including marijuana)					
<b>Prescription Drugs for Non-Medical Reasons</b>					
<b>Illegal Drugs</b> (marijuana, cocaine, crack, heroin, uppers/crank/meth, PCP, diet pills, LSD)					

**34. Which of the following statements best describes the rules about smoking inside your home now?**

**STAFF: Please read responses to participant.**

Select one only.

- € 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

**Staff: DO NOT READ OUT LOUD:**

- € Declined to answer
- €

FOLLOW UP		
<p><b>Provided information/education about:</b></p> <ul style="list-style-type: none"> <li>€ Potential effects on pregnancy of tobacco</li> <li>€ Potential effects on pregnancy of alcohol</li> <li>€ Potential effects on pregnancy of drug use</li> <li>€ Tobacco cessation</li> </ul> <p>Date _____</p>	<p><b>Provided further assessment:</b></p> <ul style="list-style-type: none"> <li>€ Assess, Advise and Assist for Alcohol Use Disorders (for “Yes” to 1 or more days of heavy drinking [for women, 4 or more drinks per day])</li> <li>€ NIDA-Modified ASSIST (for any use of illegal or prescription drug use for non-medical reasons)</li> <li>€ Provided Brief Intervention</li> </ul> <p>Date _____</p>	<p><b>Referred to:</b></p> <ul style="list-style-type: none"> <li>€ Tobacco Quit Line</li> <li>€ Behavioral Health Provider</li> <li>€ Primary Care Provider</li> <li>€ Substance abuse treatment program</li> <li>€ Other: Please specify _____</li> </ul> <p>Date _____</p>

**Personal Safety**

**35. We are concerned about the safety of all participants. Please answer the following questions about experiences that you may have had in the last 12 months so that we can help you if needed.**

**STAFF: Please read each question to participant and enter one response for each question.**

Q#	During the past 12 months...	Yes	No	Declined to Answer
35.1	Did your husband or partner threaten or make you feel unsafe in some way?			
35.2	Were you frightened for your safety or your			

	family's safety because of the anger or threats of your husband or partner?			
35.3	Did your husband or partner try to control your daily activities, for example, control who you could talk to or where you could go?			
35.4	Did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?			
35.5	Did your husband or partner force you to take part in touching or any sexual activity when you did not want to?			
35.6	Did anyone else physically hurt you in any way?			

**36. Do you keep guns in your home?**

Select one only.

- Yes
- No
- Don't know
- Declined to answer

**FOLLOW UP**

**Provided information/ education about:**

- what to do if you have or someone you know has a partner that hurts them physically
- gun safety

Date \_\_\_\_\_

- Referred to local domestic violence program. List name of program here:

\_\_\_\_\_

Date \_\_\_\_\_

## Stress and Discrimination

**STAFF: PLEASE READ OUT LOUD:**

*Stress is something we've all felt, and is often part of our daily lives. If you experience stress over a prolonged period of time however, it can be harmful to both your mind and body. Stress influences our moods, sense of well-being, behavior and overall health. We ask the following questions to learn what stressors you have in your life and to better understand how to help reduce the stress in your life.*

**37. This question is about things that may have happened during the past twelve months. For each item, check "no" if it did not happen or "yes" if it did. (It may help to look at the calendar when you answer these questions).**

**STAFF: Read each event to participant and enter one response for each event.**

Q#	Event	Yes	No
37.1	A close family member was very sick and had to go into the hospital		
37.2	I got separated or divorced from my husband or partner		
37.3	I moved to a new address		
37.4	I was homeless or had to sleep outside, in a car, or in a shelter		
37.5	My husband or partner / parent or guardian lost his/her job		
37.6	I lost my job even though I wanted to go on working		
37.7	My husband, partner, parent , guardian or I had a cut in work hours or pay.		
37.8	I was apart from my husband or partner / parent or guardian		

	due to military deployment or extended work-related travel		
37.9	I argued with my husband or partner/parent or guardian more than usual		
37.10	My husband or partner/parent or guardian said he or she didn't want me to be pregnant		
37.11	I had problems paying the rent, mortgage, or other bills		
37.12	My husband, partner, parent or guardian or I went to jail		
37.13	Someone very close to me had a problem with drinking or drugs		
37.14	Someone very close to me died		

**38. The next set of questions asks you about how other people have treated you. In your day-to-day life, how often have any of the following things happened to you? Would you say almost every day, at least once a week, a few times a year, less than once a year, or never?**

**STAFF: Read each treatment below to participant and enter one response for each treatment.**

Q#	Treatment	Almost every day	At least once a week	A few times a month	A few times a year	Less than once a year	Never	Declined to answer
38.1	You are treated with less courtesy or respect than other people.							
38.2	You receive poorer service than other people at restaurants, stores, or social services.							
38.3	People act as if they think you are not smart.							
38.4	People act as if they are afraid of you.							



38.5	You are threatened or harassed.							
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**STAFF:** If participant answers “a few times a month” or more frequently to any of the above, please go to question 39.

If participant answers “less than once a year”, “never”, or declines to answer to all of the above, go to question 40.

**39. What do you think is the main reason for these experiences?**

Select only one.

- |   |                                  |
|---|----------------------------------|
| € Your ancestry or national origins             | € Your sexual orientation        |
| € Your gender                                   | € Your education or income level |
| € Your race                                     | € Your shade of skin color       |
| € Your age                                      | € Physical Disability            |
| € Your religion                                 | € Other, please specify:         |
| € Your height                                   | _____                            |
| € Your weight                                   | _____                            |
| € Some other aspect of your physical appearance | € Don't know                     |
|   | € Declined to answer             |

## Social Support/Partner Involvement

People sometimes look to others for companionship, assistance, or other types of support. These questions ask you about the types of support that would be available to you if you needed it. If you are not sure which answer to select, please choose the one answer that comes closest to describing it.

40. For the following questions your response options are the following: None of the time, a little of the time, some of the time, most of the time or all of the time.

If you needed it, how often is someone available to...

**STAFF:** Read each support task to participant, and select only one response for each support task.

Q#	Support Task	All of the time	Most of the time	Some of the time	A little of the time	None of the time
40.1	Provide temporary financial support?					
40.2	Do something enjoyable with you?					
40.3	Help with daily chores?					
40.4	Help you if you were sick?					
40.5	Turn to for suggestions about how to deal with a personal problem?					

41. Who do you count on for support?

Select all that apply.

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>€ Current Partner</li> <li>€ Ex- partner</li> <li>€ Parents</li> <li>€ Other child or children</li> <li>€ Other relative(s)</li> </ul> | <ul style="list-style-type: none"> <li>€ Friend(s)</li> <li>€ Clergy</li> <li>€ Neighbor(s)</li> <li>€ Other _____</li> </ul> |
|---|---|

**FOLLOW UP**

Provided information/education about importance of social supports

Date \_\_\_\_\_

**Referral made to:**

- Social Worker
- Parent help line
- Parent support group
- Other: Please specify \_\_\_\_\_

Date \_\_\_\_\_

## Reproductive Life Planning

We have a few questions about your thoughts about having children. This information will help us support you in making decisions about whether and when you might become pregnant.

### 42. Do you plan to have any children?

Select one only.

- Yes (Go to question 42.1)
- No (Go to question 43)
- Unable to get pregnant **[Survey is Complete]**
- Don't know (Go to question 43)
- Declined to answer (Go to question 43)

### 42.1 How many children would you like to have?

Please enter number of children:

\_\_\_\_\_ Children (Go to question 42.2)

- Don't know
- Declined to answer

**42.2 Would you like to become pregnant in the next 12 months?**

Select one only.

- € Yes (Go to question 43)
- € No (Go to question 42.3)
- € I am okay either way (Go to question 43)
- € Don't know (Go to question 42.3)
- € Declined to answer (Go to question 42.3)

**42.3 How long would you like to wait until you become pregnant?**

Select one only.

- € 1 year -17 months
- € 18 months to 2 years
- € More than 2 years
- € Don't know
- € Declined to answer

43. Are you currently using any form of contraception or birth control to either prevent pregnancy or prevent sexually transmitted infections?

Select one only.

- € Yes (Go to question 43.1)
- € No **[Screening Tool is Complete]**
- € Don't know **[Screening Tool is Complete]**
- € Declined to answer **[Screening Tool is Complete]**

**43.1. Are you satisfied with your birth control method?**

Select one only.

- € Yes
- € No
- € Don't know
- € Declined to answer

**FOLLOW UP**

€ Provided information/education about birth control or family planning/birth spacing.

Date \_\_\_\_\_

**Provided birth control:**

- € Referred for birth control
- € Primary Care Provider
- € Planned Parenthood

€ Other: please specify \_\_\_\_\_

Date \_\_\_\_\_

**The Healthy Start Preconception Screening Tool is Complete**