

# Healthy Start Postpartum Screening Tool | August 2016

For Singleton and Multiples

OMB #: 0915-0338

Expiration Date: XX/XX/XXXX

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

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

*This tool includes questions about the new mother and should be completed for women in postpartum period. This phase refers to the time period from birth to six months after her baby is born. During this phase, Healthy Start works with mothers, infants and families to optimize maternal and newborn health. The optimal time to administer this tool is 4-6 weeks postpartum.*

Some key aims during this phase:

- Ensure quality of care for newborns
- Ensure access to quality postpartum care
- Assess for and manage mood disorders/screen for postpartum depression
- Facilitate reproductive life planning
- Provide lactation counseling and support
- Promote safe sleep

*The questions and answer choices were selected based on 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. Only read the responses to the participant if the instructions for any question tell you to do so.*

**When there is more than one baby born at a single birth (twins, triplets, etc.), the mother should answer about each child. Please remember that Child 1 should be the child that was born 1<sup>st</sup>. Child 2 should be the child that was born 2<sup>nd</sup>. Child 3 should be the child that was born 3<sup>rd</sup>. And Child 4 should be the child that was born 4<sup>th</sup>. This applies to all questions regarding the children.**

**Public Burden Statement:** An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0338. Public reporting burden for this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, MD 20857.

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**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.**

### Pregnancy Outcome

First, we'll start with questions about your pregnancy.

#### 1. Please tell me the outcome of your pregnancy.

Select one only.

- Live birth - single baby (Go to question 1.1)
- Live birth - multiples (twins, triplets, etc.) Please indicate \_\_\_\_\_ (Go to question 1.1)
- Miscarriage (Go to question 14)
- Ectopic or tubal pregnancy (Go to question 14)
- Abortion (Go to question 14)
- Fetal death/stillbirth (Go to question 1.1)
- Declined to answer (Go to question 14)

**If the outcome of the pregnancy was a miscarriage, tubal or ectopic pregnancy, abortion, or fetal death or stillbirth, staff need to be cognizant of the sensitivity of the mother, and potentially delay completing this screening tool until a more appropriate time.**

The next few questions ask about your baby/babies. Please answer for each baby, in the order that they were born. Baby 1 should be the baby that was born 1<sup>st</sup>. Baby 2 should be the baby that was born 2<sup>nd</sup>, and so forth.

#### 1.1 When was your baby / were your babies born?

**STAFF: Enter birth date for each baby.**

	Date: (month/day/year)
Baby 1	__/__/__
Baby 2	__/__/__
Baby 3	__/__/__
Baby 4	__/__/__

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**1.2 Where was your baby/were your babies born? Was it at a hospital, birthing center, home, or some other place?**

Select one response only for each baby.

	Hospital	Birthing Center	Home	Other Place (Specify):	Declined to Answer
Baby 1					
Baby 2					
Baby 3					
Baby 4					

**1.3. Was your baby/were your babies born vaginally or by C-section?**

Select one response only for each baby.

	Vaginally	C-section	Declined to Answer
Baby 1			
Baby 2			
Baby 3			
Baby 4			

**1.4 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.

- |                          |   |
|--------------------------|---|
| <p>€ Yes</p> <p>€ No</p> | <p>€ Don't know</p> <p>€ Declined to answer</p> |
|--------------------------|---|

**1.5. Did your baby/babies stay in the hospital after you came home?**

Select one response only for each baby.

	Yes	No	Declined to answer
Baby 1			
Baby 2			

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Baby 3			
Baby 4			

**1.6 How many weeks pregnant were you when your baby was/babies were born?**

**STAFF: Please enter number of weeks.**

\_\_\_\_\_ weeks

€ Don't know

€ Declined to answer

**1.7 How much did your baby/babies weigh at birth?**

**STAFF: Enter weight in pounds and ounces for each baby.**

	Weight in pounds and ounces	Don't know	Declined to answer
Baby 1	____pounds ____ounces		
Baby 2	____pounds ____ounces		
Baby 3	____pounds ____ounces		
Baby 4	____pounds ____ounces		

**STAFF: Questions 2 - 15 ask about the participants' baby or babies.  
If participant lost her baby/babies, go to question 14 [skip questions 2-13].  
Ask questions 2-13 ONLY if participant's baby/babies are living.**

### Infant Care

*The next few questions are about your baby's/babies' food and eating habits.*

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

Select one response only for each baby.

	Yes	No	Declined to answer
Baby 1			

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Baby 2			
Baby 3			
Baby 4			

**STAFF:** If any babies were breastfed, go to question 2.1  
If participant responded “no” or declined to answer for all babies, go to question 3.

**2.1 How many days, weeks or months did you breastfeed or pump breast milk for your baby/babies?**

**STAFF:** Please write in the number provided by the participant and enter number of days, weeks OR months for each baby.

	Number of days, weeks or months (record number and circle appropriate time period)	Still/Currently breastfeeding	Don't know	Declined to answer
<b>Baby 1</b>	_____ Days _____ Weeks _____ Months			
<b>Baby 2</b>	_____ Days _____ Weeks _____ Months			
<b>Baby 3</b>	_____ Days _____ Weeks _____ Months			
<b>Baby 4</b>	_____ Days _____ Weeks _____ Months			

**3. What are you currently feeding your baby/babies?**

Select all that apply for each baby.

	Breastmilk	Formula	Cereal	Other solids (Please specify)	Declined to answer
<b>Baby 1</b>					
<b>Baby 2</b>					

**Baby 3**

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**4. Do you have any concerns about your baby's/babies' feeding?**

Select one response only for each baby.

	Yes	No	Don't know	Declined to answer
Baby 1				
Baby 2				
Baby 3				
Baby 4				

**STAFF: If participant has concerns about any baby's feeding, go to question 4.1, otherwise go to question 5.**

**4.1. What is your concern?**

Select all that apply for each baby.

	Baby 1	Baby 2	Baby 3	Baby 4
Baby is having trouble latching				
Baby is distracted				
Baby is constipated				
Baby is too sleepy to eat				
Baby refuses to feed				
I worry that I may not have enough milk				
Baby is not gaining weight				
Baby is spitting up a lot after feeding				
Other (Please specify).				
Don't know				
Declined to answer				

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FOLLOW UP
<p><b>Provided information/education about:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Breastfeeding</li> <li><input type="checkbox"/> Baby nutrition</li> <li><input type="checkbox"/> Parenting</li> <li><input type="checkbox"/> Infant care</li> </ul> <p>Date _____</p> <p><b>Provided:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Breastfeeding support</li> <li><input type="checkbox"/> Counseling about parenting</li> </ul> <p>Date _____</p> <p><b>Referred to:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Breastfeeding support</li> <li><input type="checkbox"/> Nutritionist</li> <li><input type="checkbox"/> Parent Information Resource Center</li> <li><input type="checkbox"/> Parent support group</li> <li><input type="checkbox"/> Parenting classes</li> <li><input type="checkbox"/> Other: Please specify _____</li> </ul> <p>Date _____</p>

### Infant Safety

*Good sleep habits are important to your baby's/babies' physical health and emotional well-being. An important part of safe sleep is the place where your baby sleeps, his or her sleeping position, the kind of crib or bed, and type of mattress.*

**5. In which one position do you most often lie your baby/babies down to sleep now?**

**STAFF: Please read responses to participant. Select one response only for each baby.**

	On his or her side	On his or her back	On his or her stomach	Declined to answer
<b>Baby 1</b>				
<b>Baby 2</b>				
<b>Baby 3</b>				
<b>Baby 4</b>				

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**6. In the past 2 weeks, how often has your new baby/have your new babies slept alone in his or her/their own crib or bed? Would you say always, often, sometimes, rarely, or never?**

*Select one response only for each baby.*

Responses	Always	Often	Sometimes	Rarely	Never	Don't know	Declined to answer
Baby 1							
Baby 2							
Baby 3							
Baby 4							

**7. Please tell us how your new baby/ babies most often slept in the past 2 weeks.**

**STAFF: PLEASE READ each sleeping location to participant and select a response for each sleeping location for each baby.**

Sleeping Location	Baby 1	Baby 2	Baby 3	Baby 4
In a crib, bassinet, or pack and play				
On a twin or larger mattress or bed				
On a couch, sofa, or armchair				
In an infant car seat or swing				
With a blanket				
With toys, cushions, or pillows, including nursing pillows				
With crib bumper pads (mesh or non-mesh)				
In a sleeping sack or wearable blanket				



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**8. When your baby/babies 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?**

Select one response only for each baby.

	Always	Often	Sometimes	Rarely	Never	Don't know	Declined to answer
Baby 1							
Baby 2							
Baby 3							
Baby 4							

**9. On average, how many hours per day is your baby/are your babies in the same room or vehicle with another person who is smoking?**

Please enter number of hours baby is in the same room or vehicle with another person who is smoking, or select one response only for each baby.

	Number of hours per day	Baby spends less than one hour per day in a room or vehicle with somebody who is smoking	Baby is never in a room or vehicle with someone who is smoking	Declined to answer
Baby 1				
Baby 2				
Baby 3				
Baby 4				

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### FOLLOW UP

**Provided information/education about:**

- Safe sleep positions, safe sleep environment
- Car seat safety (installation, placement in car, rear facing, checking weight and height limits)
- Effects of tobacco exposure on infant

Date \_\_\_\_\_

**Provided:**

- Crib
- Car seat

Date \_\_\_\_\_

**Referred for:**

- Crib
- Crib assembly
- Car seat
- Car seat installation
- Car seat installment education

**Name of local organization(s) providing services** \_\_\_\_\_

Date \_\_\_\_\_

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### Baby Insurance / Access to Care / Medical Home

**A personal doctor or nurse is a health professional who knows your baby well and is familiar with your baby’s health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician’s assistant.**

**10. Do you have one or more persons you think of as your baby’s/babies’ personal doctor or nurse?**

Select one response only for each baby.

	Yes, one person	Yes, more than one person	No	Don’t Know	Declined to Answer
<b>Baby 1</b>					
<b>Baby 2</b>					
<b>Baby 3</b>					
<b>Baby 4</b>					

**11. Is there a place that your baby/babies USUALLY goes/go for care when he or she is sick or when you or another caregiver need advice about your baby’s health?**

Select one response only for each baby.

	Yes	No	There is more than one place	Don’t Know	Declined to Answer
<b>Baby 1</b>					
<b>Baby 2</b>					
<b>Baby 3</b>					
<b>Baby 4</b>					

**If baby has/babies have one or more usual place for care, go to question 11.1**

**If baby has/babies have no usual place, don’t know, or declined to answer, go to question 12.**

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**11.1 What kind of place does your baby/ do your babies go to most often when he/she is sick or you need advice about his/her health? Is it a doctor's office, emergency room, hospital outpatient department, clinic or some other place?**

Select one only for each baby.

	Baby 1	Baby 2	Baby 3	Baby 4
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				

**12. When was your baby's/babies' last visit to a doctor, nurse, or other health provider for a well-child check-up?**

Select one response only for each child.

	Date of baby's last visit	Don't know	Declined to answer
Baby 1	__ / __ / ____		
Baby 2	__ / __ / ____		
Baby 3	__ / __ / ____		
Baby 4	__ / __ / ____		

**STAFF: Go to question 12.1**

**12.1 Did your baby/babies receive vaccines during this visit?**

Select one response only for each child.

	Yes	No	Don't know	Declined to answer
Baby 1				
Baby 2				
Baby 3				
Baby 4				

**13. Please tell me what kind of health insurance your baby has/babies have:**

Select all that apply for each baby.

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	Baby 1	Baby 2	Baby 3	Baby 4
Private health insurance through my job, or 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				

FOLLOW UP
<p><b>Provided information/education about:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Importance of regular visits to primary care provider</li> <li><input type="checkbox"/> Importance of receiving vaccines on schedule</li> <li><input type="checkbox"/> Medicaid eligibility</li> </ul> <p><b>Date</b> _____</p> <p><b>Provided Service:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Enrolled in Medicaid</li> </ul> <p><b>Date</b> _____</p> <p><b>Provided vaccines:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hepatitis B</li> <li><input type="checkbox"/> Diphtheria, Tetanus, Pertussis (DTaP)</li> <li><input type="checkbox"/> Haemophilus influenzae Type B (Hib)</li> <li><input type="checkbox"/> Pneumococcal</li> <li><input type="checkbox"/> Inactivated Poliovirus (IPV)</li> <li><input type="checkbox"/> Influenza (Flu)</li> <li><input type="checkbox"/> Measles, Mumps, Rubella (MMR)</li> </ul>

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- Varicella
- Hepatitis A

Date \_\_\_\_\_

### Referred for:

- Medicaid enrollment
- Primary Care Provider
- Pediatrician

Date \_\_\_\_\_

## Reproductive Life Planning

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

### 14. Do you plan to have any more children?

Select one only.

- Yes (Go to question 14.1)
- No (Go to question 15)
- Unable to get pregnant (Go to question 16)
- Don't know (Go to question 15)
- Declined to answer (Go to question 15)

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

**STAFF: Please enter the number of children.**

\_\_\_\_\_ Children

- Don't know
- Declined to answer

#### 14.2 Would you like to become pregnant in the next 12 months?

Select one only.

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- Yes (Go to question 15)
- No (Go to question 14.3)
- I am okay either way (Go to question 15)
- Don't know (Go to question 15)
- Declined to answer (Go to question 15)

### 14.3 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

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

Select one only.

- Yes (Go to question 15.1)
- No (Go to question 16)
- Don't know (Go to question 16)
- Declined to answer (Go to question 16)

15.1. Are you satisfied with your birth control method?

Select one only.

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

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### FOLLOW UP

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

Date \_\_\_\_\_

Provided counseling about family planning

Provided birth control

Referred for birth control

Primary Care Provider

Planned Parenthood

Other: please specify \_\_\_\_\_

Date \_\_\_\_\_

### Social Determinants of Health

Now, I would like to ask a few questions to provide us with some background information.

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

Select one only.

Married or living with a partner

Separated

Divorced

Widowed

Never married

Declined to answer

**17. Are you currently...**

**STAFF: Please read responses out loud to participant:**

Select one only.

Employed for wages

Self-employed

Out of work for 1 year or more

Out of work for less than 1 year

A Homemaker

A Student



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- Retired
- Unable to work

**Staff: DO NOT READ OUT LOUD**

- Declined to answer

**18. 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.

- Less than \$10,000
- \$10,000 to less than \$15,000
- \$15,000 to less than \$20,000
- \$20,000 to less than \$25,000
- \$25,000 to less than \$35,000
- \$35,000 to less than \$50,000
- \$50,000 or more
- Don't know
- Declined to answer

**19. 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

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

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Declined to answer

*Now I would like to ask you about your current housing.*

**21. What is the zip code where you live?**

\_\_\_\_\_

Don't know

Declined to answer

**22. 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 22.1)

Rents or shares own home or apartment (Go to question 22.1)

Lives in public housing (receives rental assistance, such as Section 8) (Go to question 22.1)

Lives with parent or family member (Go to question 22.1)

Homeless (Go to question 22.2)

Some other arrangement (Please specify): \_\_\_\_\_ (Go to question 22.1)

Declined to answer (Go to question 23)

**22.1 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 23)

Declined to answer (Go to question 23)

No (Go to question 23)

Don't know (Go to question 23)

**22.2 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

Some other arrangement (please specify): \_\_\_\_\_

Lives in an emergency or transition shelter

Declined to answer

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### 23. Do you have any housing concerns?

Select one only.

- Yes (Go to question 23.1)
- No (Go to question 24)
- Don't know (Go to question 24)
- Declined to answer (Go to question 24)

#### 23.1 What issues concern you about your housing situation?

Select all that apply.

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

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**24. 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 support services to participant and enter an answer for each service.**

Support Service	Receiving	Have applied for	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)					

**25. Do you currently have an open case with Child Protective Services?**

Select one only.

€ Yes

€ No

€ Don't know

€ Declined to answer

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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><b>Date</b> _____</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><b>Date</b> _____</p>

### Neighborhood and Community

**26. 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.

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

**27. 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<br><input type="radio"/> Sometimes<br><input type="radio"/> Usually | <input type="radio"/> Always<br><input type="radio"/> Declined to answer |
|---|--|

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

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

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## For Singleton and Multiples

OMB #: 0915-0338  
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### Medical Home / Access to Care/Health Insurance

***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.***

**30. Do you have one or more persons you think of as your personal doctor or nurse?**

Select one only.

- |   |  |
|---|--|
| <input type="radio"/> Yes, one person           | <input type="radio"/> Don't know         |
| <input type="radio"/> Yes, more than one person | <input type="radio"/> Declined to answer |
| <input type="radio"/> No                        |  |

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

- |  |  |
|--|--|
| <input type="radio"/> Yes (Go to question 31.1)                          | <input type="radio"/> Don't know (Go to question 32)         |
| <input type="radio"/> No (Go to question 32)                             | <input type="radio"/> Declined to answer (Go to question 32) |
| <input type="radio"/> There is more than one place (go to question 31.1) |  |

**31.1. 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.

- |  |  |
|--|--|
| <input type="radio"/> Doctor's Office                | <input type="radio"/> Retail Store Clinic or "Minute Clinic"             |
| <input type="radio"/> Hospital Emergency Room        | <input type="radio"/> School (Nurse's Office, Athletic Trainer's Office) |
| <input type="radio"/> Hospital Outpatient Department | <input type="radio"/> Some other place                                   |
| <input type="radio"/> Clinic or Health Center        |  |

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### 32. Please tell me what kind of health insurance you have:

Select all that apply.

- |   |  |
|---|--|
| <input type="checkbox"/> Private health insurance through my job, or the job of my husband, partner or parents                              | <input type="checkbox"/> TRICARE or other military health care |
| <input type="checkbox"/> Insurance purchased directly from an insurance company   | <input type="checkbox"/> Indian Health Service                 |
| <input type="checkbox"/> Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability | <input type="checkbox"/> Other, specify: _____                 |
|   | <input type="checkbox"/> No insurance                          |
|   | <input type="checkbox"/> Don't know                            |
|   | <input type="checkbox"/> Declined to answer                    |

### 33. Since your child was /children were born, have you had a postpartum visit for yourself? A postpartum visit is the regular checkup a woman has 4-6 weeks after she gives birth.

Select one only.

- Yes (Go to question 33.1)
- No (Go to question 33.2)
- Don't know (Go to question 33.2)

#### 33.1 When did you have your postpartum visit?

**STAFF: Please enter day of postpartum visit.**

\_\_\_ / \_\_\_ / \_\_\_\_ (month/day/year) (Go to question 33)

#### 33.2 Do you have one scheduled?

Select one only.

- Yes: Please indicate date of scheduled appointment: \_\_\_ / \_\_\_ / \_\_\_\_ (month/day/year)
- No
- Declined to answer



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### FOLLOW UP

**Provided information/education about:**

- Importance of regular postpartum care
- Importance of having a regular provider/medical home
- Medicaid eligibility
- Birth spacing

Date \_\_\_\_\_

**Provided Service:**

- Enrolled in Medicaid

Date \_\_\_\_\_

**Referred for:**

- Medicaid enrollment
- OB/GYN provider
- Primary Care Provider

Date \_\_\_\_\_

### Maternal Health

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

Select one only.

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Poor               |
| <input type="checkbox"/> Very good | <input type="checkbox"/> Don't know         |
| <input type="checkbox"/> Good      | <input type="checkbox"/> Declined to answer |
| <input type="checkbox"/> Fair      |   |

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

Select one only.

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Poor               |
| <input type="checkbox"/> Very good | <input type="checkbox"/> Don't know         |
| <input type="checkbox"/> Good      | <input type="checkbox"/> Declined to answer |
| <input type="checkbox"/> Fair      |   |

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### 36.1 How tall are you without shoes?

Please enter height in feet and inches.

\_\_\_\_\_ Feet \_\_\_\_\_ Inches  
 Don't Know

Declined to answer

### 36.2 Just before you got pregnant with your new baby, how much did you weigh?

Please enter weight in pounds.

\_\_\_\_\_ Pounds  
 Don't Know

Declined to answer

### 36.3 How much do you weigh now?

Please enter weight in pounds.

\_\_\_\_\_ Pounds  
 Don't Know

Declined to answer

### 37. 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

### 38. 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

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**39. 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
<p><b>Provided information/education about:</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> Keeping a healthy weight such as through diet and exercise</li> <li><input type="radio"/> Getting flu shot</li> <li><input type="radio"/> Keeping teeth healthy</li> </ul> <p>Date _____</p> <p><b>Provided:</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> Nutritional counseling</li> <li><input type="radio"/> Flu vaccines</li> </ul> <p>Date _____</p> <p><b>Referred to:</b></p> <ul style="list-style-type: none"> <li><input type="radio"/> Primary Care Provider</li> <li><input type="radio"/> Nutritionist</li> <li><input type="radio"/> Dentist</li> <li><input type="radio"/> Other: Please specify _____</li> </ul> <p>Date _____</p>

### Mental Health

**40. 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	Nearly every day	Score

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				days		
40.1	Little interest or pleasure in doing things	0	1	2	3	
40.2	Feeling down, depressed, or hopeless	0	1	2	3	
	<b>Total Score</b>					

**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.

<b>FOLLOW UP</b>
<p><b>Provided information/ education about:</b></p> <ul style="list-style-type: none"> <li>€ Postpartum depression or “Baby Blues”</li> <li>€ Local resources for depression</li> </ul> <p><b>Date</b> _____</p> <p><b>Provided:</b></p> <ul style="list-style-type: none"> <li>€ Further assessment using evidence-based tool such as the Edinburgh Postnatal Depression Scale (EPDS)</li> <li>€ Counseling</li> </ul> <p><b>Date</b> _____</p> <p><b>Referred to:</b></p> <ul style="list-style-type: none"> <li>€ Mental health center</li> <li>€ Primary Care Provider</li> <li>€ Other: Please specify _____</li> </ul> <p><b>Date</b> _____</p>

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### 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.*

**41. 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
Alcohol (4 or more drinks per day)					
Tobacco Products (including cigarettes, chewing tobacco, snuff, iqmik, or other tobacco products like snus Camel Snus, orbs, e-cigarettes, lozenges, cigars, or hookah)					
Mood-altering Drugs (including marijuana)					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs (marijuana, cocaine, crack, heroin, uppers/krank/meth, PCP, diet pills, LSD)					

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**42. Did you smoke any cigarettes or use any tobacco products during the last 3 months of your pregnancy?**

Select one only.

- € Yes (Go to question 42.1)
- € No (Go to question 43)
- € Don't know (Go to question 43)
- € Declined to answer (Go to question 43)

**42.1. During the last 3 months of your pregnancy, how many cigarettes did you smoke on an average day?**

Select one only.

- € 41 cigarettes or more
- € 21 to 40 cigarettes
- € 11 to 20 cigarettes
- € 6 to 10 cigarettes
- € 1 to 5 cigarettes
- € Less than 1 cigarette
- € Declined to answer

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

Select one only.

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

- € 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
- € Declined to answer

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

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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>€ <b>Provided Brief Intervention</b></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

**44. We are concerned about the safety of all participants. Please answer the following questions about experiences that you may have had during the past 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
44.1	Did your husband or partner threaten or make you feel unsafe in some way?			
44.2	Were you frightened for your safety or your family’s safety because of the anger or threats of your husband or partner?			
44.3	Did your husband or partner try to control your daily activities, for			

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	example, control who you could talk to or where you could go?			
44.4	Did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?			
44.5	Did your husband or partner force you to take part in touching or any sexual activity when you did not want to?			
44.6	Did anyone else physically hurt you in any way?			

### 45. Do you keep guns in your home?

Select one only

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

FOLLOW UP
<p><b>Provided information / education about:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> What to do if you have or someone you know has a partner that hurts them physically</li> <li><input type="checkbox"/> Gun safety</li> </ul> <p><b>Date</b> _____</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Referred to local domestic violence program</li> </ul> <p style="padding-left: 40px;">_____</p> <p><b>Date</b> _____</p>



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### Stress and Discrimination

*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.*

**46. This question is about things that may have happened during the past twelve months. For each item, tell me "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
46.1	A close family member was very sick and had to go into the hospital		
46.2	I got separated or divorced from my husband or partner		
46.3	I moved to a new address		
46.4	I was homeless or had to sleep outside, in a car, or in a shelter		
46.5	My husband or partner / parent or guardian lost his or her job		
46.6	I lost my job even though I wanted to go on working		
46.7	My husband, partner, parent, guardian or I had a cut in work hours or pay.		
46.8	I was apart from my husband or partner / parent or guardian due to military deployment or extended work-related travel		
46.9	I argued with my husband or partner / parent or guardian more than usual		
46.10	My husband or partner / parent or guardian said he or she didn't want me to be pregnant		
46.11	I had problems paying the rent, mortgage, or other bills		
46.12	My husband, partner, parent, guardian or I went to jail		
46.13	Someone very close to me had a problem with drinking or drugs		
46.14	Someone very close to me died		

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**47. 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
47.1	You are treated with less courtesy or respect than other people.							
47.2	You receive poorer service than other people at restaurants, stores, or social services.							
47.3	People act as if they think you are not smart.							
47.4	People act as if they are afraid of you.							
47.5	You are threatened or harassed.							

If participant answers “a few times a year” or more frequently for any of the above, go to question 48.

If participant answers “less than once a year” or “never” to all of the above, go to question 49.

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### 48. What do you think is the main reason for these experiences?

Select one only.

- |  |  |
|--|--|
| <input type="checkbox"/> Your ancestry or national origins             | <input type="checkbox"/> Your sexual orientation         |
| <input type="checkbox"/> Your gender                                   | <input type="checkbox"/> Your education or income level  |
| <input type="checkbox"/> Your race                                     | <input type="checkbox"/> Your shade of skin color        |
| <input type="checkbox"/> Your age                                      | <input type="checkbox"/> Physical Disability             |
| <input type="checkbox"/> Your religion                                 | <input type="checkbox"/> Other, please specify:<br>_____ |
| <input type="checkbox"/> Your height                                   | _____  |
| <input type="checkbox"/> Your weight                                   | <input type="checkbox"/> Don't know                      |
| <input type="checkbox"/> Some other aspect of your physical appearance | <b>Staff: DO NOT READ OUT LOUD:</b>                      |
|  | <input type="checkbox"/> Declined to answer              |

#### FOLLOW UP

- Provided information/ education about resources for stress management

Date \_\_\_\_\_

- Provided counseling on stress management

Date \_\_\_\_\_

#### Referred to:

- Mental health center  
 Primary Care Provider  
 Other: Please specify \_\_\_\_\_

Date \_\_\_\_\_

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### Social Support / Father or 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.*

**49. 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
49.1	Provide temporary financial support?					
49.2	Do something enjoyable with you?					
49.3	Help with daily chores?					
49.4	Help you if you were sick?					
49.5	Turn to for suggestions about how to deal with a personal problem?					
49.6	To watch your baby for you?					

**50. Would you describe your partner or the father of your baby/babies as:**

**STAFF: Please read responses to participant, and select only one response.**

- € Involved and supportive of me and my baby/babies (Go to question 49.1)
- € Involved but not supportive of me or my baby/babies (Go to question 49.1)
- € Not involved **[Screening tool is complete]**

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

- € Declined to answer **[Screening tool is complete]**

**50.1. What is your partner's or the father of your baby's /babies' role in your life?**

*Select all that apply.*

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- € Partner or father of baby/babies is deceased
- € Partner or father of baby/babies is incarcerated
- € Cares for baby/babies (feeding, bathing, etc.)
- € Assists with housework and/or runs errands (ex: grocery shopping)
- € Attends medical appointments
- € Provides emotional support
- € Provides financial support
- € Partner or father of baby/babies plays no role/is not involved
- € Other (please specify): \_\_\_\_\_
- € Declined to answer

### 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 \_\_\_\_\_

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