Healthy Start Interconception/Parenting Screening Tool | August 2016 | Singleton and Multiples

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

Name: _____

Completed by: _____ **Date of Administration:** _____

This tool should be completed with women and children in the period beyond the immediate postpartum phase. This phase refers to the time period from age 6 months to two years after delivery. During this phase, Healthy Start works with mothers, children and families to strengthen family resilience, creating a foundation for optimal child health and development.

Administer this tool at 6 months after delivery, 1 year after delivery and just prior to the completion of the program at 2 years *(to ensure child and Mom are ready to leave program with supports in place)*.

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 1st.Child 2 should be the child that was born 2nd. Child 3 should be the child that was born 3rd. And Child 4 should be the child that was born 4th. This applies to all questions regarding the children.

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.*

Child Health Status

I am going to start off by asking some questions about your child/children.

1. ***Please tell me the dates of birth for any children older than 6 months and younger than 24 months old.***

	Date of Birth	Don't know	Declined to answer
Child 1	__ / __ / ____		
Child 2	__ / __ / ____		
Child 3	__ / __ / ____		
Child 4	__ / __ / ____		

1.1 How would you describe this child's/these children's health?

	Excellent	Very Good	Good	Fair	Poor	Child is deceased
Child 1						
Child 2						
Child 3						
Child 4						

STAFF:

If any child is deceased, you will need to be aware of the sensitivity of the mother, and potentially delay completing this screening tool until a more appropriate time.

STAFF: Questions 2 - 15 ask about the participants' baby or babies.

If participant has lost her baby/babies, ask question 2, and go to question 16 [skip questions 2.1- 15]. Ask questions 3 – 15 ONLY if participant's baby/babies are living.

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

Select one only for each child.

	Yes	No	Declined to answer
Child 1			
Child 2			
Child 3			
Child 4			

STAFF: If any children were breastfed, go to question 2.1
If participant responded "no" or declined to answer for all children, go to question 3.

2.1 How many days, weeks or months did you breastfeed or pump breast milk for your child/children?

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

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

3. Please tell me the number of times you or a family member read to your child during the past week. Reading includes books with words or pictures but not books read by an audio tape, record, CD, or computer.

STAFF: Record the total number of days, from 0 days (no days) to 7 days (everyday).

	Times per week (Record the number)	Don't know	Declined to answer
Child 1			
Child 2			
Child 3			
Child 4			

4. Your child's development is important. I have some questions about your child's development. Please let me know if you or anyone else has concerns about the following.

STAFF: Please ask each question below and select a response for each question.

Q#	Are you or anyone else concerned about:	Yes	No	Don't know	Declined to answer
4.1	How your child talks, makes speech sounds, or understands?				
4.2	How your child uses his or her arms or legs?				
4.3	How your child uses his or her hands or fingers to do things?				
4.4	How your child is learning to do things for himself or herself?				
4.5	How your child behaves or gets along with others?				

FOLLOW UP

- € **Provided information/education about child development**
- € **Provided information/education about parenting**

Date _____

- € **Provided counseling about parenting**

Date _____

Referred to:

- € Parent Information Resource Center
- € Parent support group
- € Parenting classes
- € Other: Please specify _____

Date _____

Child Safety

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

STAFF: Ask questions 5, 6, 7 about safe sleep for children less than 12 months old only.

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 child.

	On his or her side	On his or her back	On his or her stomach	Declined to answer
Child 1				
Child 2				
Child 3				
Child 4				

6. In the past 2 weeks, how often has your new child/have your new children 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 child.

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

7. Please tell us how your child/children 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 child.

Sleeping Location	Child 1	Child 2	Child 3	Child 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				

8. When your child/children 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 child.

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

9. Has your child / have your children been tested for lead?

Select one response only for each child

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

STAFF: If any has been tested for lead, go to question 9.1, otherwise go to question 10.

9.1 Did your child's lead levels concern the doctor?

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

10. On average, how many hours per day is <u>your child/are your children</u> in the same room or vehicle with another person who is smoking?

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

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

11. Do you keep guns in your home?

Select one only.

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

FOLLOW UP

Provided information/education about:

- € Safe sleep positions
- € Car seat safety (installation, placement in car, rear facing, weight and height limits)
- € Lead poisoning
- € Effects of tobacco exposure
- € Gun Safety

Date _____

Provided:

- € Crib
- € Car seat
- € Lead testing

Date _____

Referred for:

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

Name of local organization(s) providing services_____

Primary care provider for lead testing_____

Date _____

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

Child Insurance / Access to Care / Medical Home

A personal doctor or nurse 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.

12. Do you have one or more persons you think of as your child's personal doctor or nurse?

Select one response only for each child.

	Yes, one person	Yes, more than one person	No	Don't Know	Declined to Answer
Child 1					
Child 2					
Child 3					
Child 4					

13. Is there a place that your child USUALLY goes for care when he or she is sick or when you or another caregiver need advice about your child's health?

Select one response only for each child.

	Yes	No	There is more than one place	Don't Know	Declined to Answer
Child 1					
Child 2					
Child 3					
Child 4					

If child has/children have one or more usual place for care, go to question 13.1

If child has/children have no usual place, don't know, or declined to answer, go to question 14.

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

Select one response only for each child.

	Child 1	Child 2	Child 3	Child 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				

14. Please tell me what kind of health insurance your child has:

Select all that apply for each child.

	Child 1	Child 2	Child 3	Child 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				

15. When was your child's 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 child's last visit	Don't know	Declined to answer
Child 1	__ / __ / ____		
Child 2	__ / __ / ____		
Child 3	__ / __ / ____		
Child 4	__ / __ / ____		

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

15.1 Did your child receive age-appropriate vaccines during this visit?

Select one response only for each child.

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

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

Reproductive Life Planning

16. Are you pregnant now?

Select one only.

- € Yes **(Skip questions 17 – 58, go to questions 59 - 59.1, then complete Prenatal Screening Tool)**
- € No (Go to question 17)
- € Don't know (Go to question 17)
- € Declined to answer (Go to question 17)

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.

17. Do you plan to have any more children?

Select one only.

- € Yes (Go to question 17.1)
- € No (Go to question 18)
- € Unable to get pregnant (Go to question 19)
- € Don't know (Go to question 18)
- € Declined to answer (Go to question 18)

17.1 How many children would you like to have?

STAFF: Please enter the number of children.

_____Children

- € Don't know
- € Declined to answer

17.2 Would you like to become pregnant in the 12 months?

Select one only.

- € Yes (Go to question 18)
- € No (Go to question 18)
- € I am okay either way (Go to question 17.3)
- € Don't know (Go to question 18)
- € Declined to answer (Go to question 18)

17.3 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

18. ***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 18.1)
€ No (Go to question 19)
€ Declined to answer (Go to question 19)

18.1. 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 counseling about family planning** € **Provided birth control** € **Referred for birth control** o **Primary Care Provider** o **Planned Parenthood** o **Other: please specify _____** **Date _____**

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

Social Determinants of Health

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

19. 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

20. Are you currently…

STAFF: Please read responses out loud to participant.

Select only one.

- € 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
- € Retired
- € Unable to work

Staff: DO NOT READ OUT LOUD

- € Declined to answer

21. 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

22. 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

23. 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.
- € Declined to answer

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

24. What is the zip code where you live?

- € Don't know
- € Declined to answer

25. 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 25.1)
- € Rents or shares own home or apartment (Go to question 25.1)
- € Lives in public housing (receives rental assistance, such as Section 8) (Go to question 25.1)
- € Lives with parent or family member (Go to question 25.1)
- € Homeless (Go to question 25.2)
- € Some other arrangement (Please specify): _____ (Go to question 25.1)
- € Declined to answer (Go to question 25.2)

25.1 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 26)
- € No (Go to question 26)
- € Don't know (Go to question 26)
- € Declined to answer (Go to question 26)

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

25.2 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 (please specify): _____
- € Declined to answer

26. Do you have any housing concerns?

Select one only.

- € Yes (Go to question 26.1)
- € No (Go to question 27)
- € Don't know (Go to question 27)
- € Declined to answer (Go to question 7)

26.1 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

27. 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	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)						

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

Select one only.

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

FOLLOW UP	
Provided information/education about: € 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) **Date _____**	**Referral made for:** € 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) **Date _____**

Neighborhood and Community

29. 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
29.1	People in this neighborhood or community help each other out				
29.2	We watch out for each other's children in this neighborhood or community				
29.3	If my child was outside playing and got hurt or scared, there are adults nearby who I trust to help my child.				
29.4	I feel comfortable letting my child play outside alone.				

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

Select one only.

- € Never
- € Sometimes
- € Usually
- € Always
- € Declined to answer

31. 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.

- € Daily
- € Weekly
- € Monthly
- € A few times a year
- € Less than once a year
- € Never
- € Declined to answer

32. 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.

- € Daily
- € Weekly
- € Monthly
- € A few times a year
- € Less than once a year
- € Never
- € Declined to answer

Medical Home / Access to Care

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.

33. 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
- € Don't know (Go to question 34)
- € Declined to answer (Go to question 34)

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

- € Yes (Go to question 34.1)
- € No (Go to question 35)
- € There is more than one place (go to question 34.1)
- € Don't know (Go to question 34)
- € Declined to answer (Go to question 34)

34.1. 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

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

Select all that apply.

- € 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

36. 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

FOLLOW UP
Provided information/education about: € Importance of regular preventative 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

37. 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

38. 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

39.1 How tall are you without shoes?

Please enter height in feet and inches.

_____Feet _____ Inches

- € Don't Know
- € Declined to answer

39.2 How much do you weigh?

Please enter weight in pounds.

_____ Pounds

- € Don't Know
- € Declined to answer

40. Did you have a postpartum checkup after your child was born?

Select one only.

- € Yes (Go to question 40.1)
- € No (Go to question 41)
- € Declined to answer (Go to question 41)

40.1. Approximately how many weeks postpartum did you have your postpartum checkup?

_____Number of Weeks

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

Select one response only for each question. If participant has a condition, please as if they currently have this condition.

Cardiovascular disease (heart problems)

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

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

Asthma (breathing problems/wheezing)

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

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

Depression or other mental health conditions (anxiety, bipolar)

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

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

Diabetes (high blood sugar)

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

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

Gestational Diabetes

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

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

Eating disorders (anorexia/bulimia)

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

- € Yes
- € No
- € 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 Deficiency 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 (Go to question 39.1)
- € No (Go to question 40)
- € Don't know (Go to question 40)
- € Declined to answer (Go to question 40)

STAFF: If participant currently has any of the above conditions, go to question 41.1.

If participant does not currently have any of the above conditions, go to question 42.

41.1 Please tell me which condition or conditions you have been seen for by a health care 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)
- € Gestational diabetes
- € 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)

42. Are you currently having any pain?

Select one only.

- € Yes
- € No
- € Declined to answer

43. Are you taking any prescription medications?

Select one only.

- € Yes (Go to question 43.1)
- € No (Go to question 44)
- € Don't know (Go to question 44)
- € Declined to answer (Go to question 44)

43.1 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)				

44. 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
- € Don't know
- € Declined to answer

45. 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

46. 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

47. 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
47.1	MMR (measles, mumps, rubella) vaccine				
47.1.1	**If not,** have you been tested for immunity to rubella?				
47.2	Hepatitis B vaccine (3 doses)				
47.3	All 3 shots of the Gardasil (HPV virus) vaccine				
47.4	Have you ever had chicken pox or shingles?				
47.4.1	**If not,** have you received 2 doses of the varicella vaccine?				
47.5	In the last 10 years, have you received Tdap (tetanus, diphtheria, and pertussis)?				

48. 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:						

49. 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.

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

50. 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.

- € Less than six months ago
- € Six months to one year ago
- € More than one year ago
- € Never
- € Don't know
- € Declined to answer

FOLLOW UP
Provided information/education about: € Keeping a healthy weight such as through diet and exercise € Getting vaccines € Getting flu shot € 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

51. 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
51.1	Little interest or pleasure in doing things	0	1	2	3	
51.2	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
Provided information/education about: € Local resources for depression **Date**_____ **Provided Service:** € Further assessment using evidence-based tool such as PHQ-9 € Counseling **Date**_____ **Referred to:** € Mental health center € Primary Care Provider € Other: Please specify_____ **Date**_____

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.

52. 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/crank/meth, PCP, diet pills, LSD)					

53. Which of the following statements best describes the rules about smoking inside your home?

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

DO NOT READ OUT LOUD:

- € Declined to answer

FOLLOW UP

Provided information/education about: € Potential effects on pregnancy of tobacco € Potential effects on pregnancy of alcohol € Potential effects on pregnancy of drug use € Tobacco cessation **Date**_____	**Provided further assessment:** € 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]) € NIDA-Modified ASSIST (for any use of illegal or prescription drug use for non-medical reasons) € **Provided Brief Intervention** Date_____	**Referred to:** € Tobacco Quit Line € Behavioral Health Provider € Primary Care Provider € Substance abuse treatment program € Other: Please specify_____ **Date**_____

Personal Safety

54. 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
54.1	Did your husband or partner threaten or make you feel unsafe in some way?			
54.2	Were you frightened for your safety or your family's safety because of the anger or threats of your husband or partner?			
54.3	Did your husband or partner try to control your daily activities, for example, control who you could talk to or where you could go?			
54.4	Did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?			
54.5	Did your husband or partner force you to take part in touching or any sexual activity when you did not want to?			
54.6	Did anyone else physically hurt you in any way?			

FOLLOW UP

€ **Provided information/ education about what to do if you have or someone you know has a partner that hurts them physically**

Date _____

€ **Referred to local domestic violence program** _____

Date _____

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.

55. This question is about things that may have happened during the past twelve months. For each item, please 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
55.1	A close family member was very sick and had to go into the hospital		
55.2	I got separated or divorced from my husband or partner		
55.3	I moved to a new address		
55.4	I was homeless or had to sleep outside, in a car, or in a shelter		
55.5	My husband or partner / parent or guardian lost his or her job		
55.6	I lost my job even though I wanted to go on working		
55.7	My husband, partner, parent, guardian or I had a cut in work hours or pay.		
55.8	I was apart from my husband or partner / parent or guardian due to military deployment or extended work-related travel		
55.9	I argued with my husband or partner / parent or guardian more than usual		
55.10	My husband or partner / parent or guardian said he or she didn't want me to be pregnant		
55.11	I had problems paying the rent, mortgage, or other bills		
55.12	My husband, partner, parent, guardian or I went to jail		
55.13	Someone very close to me had a problem with drinking or drugs		
55.14	Someone very close to me died		

56. 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
56.1	You are treated with less courtesy or respect than other people.							
56.2	You receive poorer service than other people at restaurants, stores, or social services.							
56.3	People act as if they think you are not smart.							
56.4	People act as if they are afraid of you.							
56.5	You are threatened or harassed.							

STAFF:
If participant answers “a few times a year” or more frequently to any of the above, go to question 57.
If participant answers "less than once a year", "never" or declines to answer for all of the above, go to question 58.

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

Select one only.

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

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.

58. 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
58.1	Provide temporary financial support?					
58.2	Do something enjoyable with you?					
58.3	Help with daily chores?					
58.4	Help you if you were sick?					
58.5	To turn to for suggestions about how to deal with a personal problem?					
58.6	To watch your child for you?					

STAFF: Please ask the next two questions only if child is alive.

59. Would you describe your partner or the father of your child/children as:

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

- € Involved and supportive of me and my child/children
- € Involved but not supportive of me or my child/children
- € Not involved

Staff: DO NOT READ OUT LOUD:

Declined to answer

59.1. What is your partner's or the father of your child's role in your life?

Staff: select the responses below that best matches the participant's response.

- € Partner or father of child/children is deceased
- € Partner or father of child/children is incarcerated
- € Cares for child/children (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 child/children 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 Interconception/Parenting Screening Tool is Complete