Healthy Start
Infant/Child Initial Assessment

Family/Home

Ask the child's parent/guardian what they feel are the family's assets, strengths and resources.
Ex: "What is working well for your family now? What are some of the positive things in your family's life?" Note below.
Family Assets, Strengths, and Resources

____
____
____
____
____

Ask the child's parent/guardian "What are the family's main concerns now that they have a young child?"
"Is there anything that is a worry right now?" Note below.
Family Concerns

____
____
____
____
____

Through your discussion with the child's parent, please determine nutritional practices of the participant. Note below.
Nutritional Assessment

☐ Receiving WIC
☐ Food allergies
☐ Raw or undercooked meats/seafood consumed
☐ Dietary supplements
☐ Type of feeding (breast, bottle, combination, or tube feeding; solid foods)
  -If bottle-feeding or tube feeding, type of formula; amount at each feeding.
☐ Feeding frequency
☐ Cereal in bottle
☐ Juice in bottle
☐ Drinking from cup
☐ Age started solids
☐ Types of solids
  -Type and amount of solids consumed daily
☐ Nutrition-related medical conditions
☐ Ethnic supplements

Ask the child's parent/guardian what prescribed medications or over the counter medications, the participant is currently taking, and how often. Please note below.
Medication/Supplements

☐ Vitamins/ iron ____________________________
☐ Medications (prescription and over the counter) ____
☐ Herbal ________________________________
☐ Supplements ________________________________
☐ Other ________________________________

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Through interview, if face to face visit is in the community, or observation, if face to face visit is in the participant's home, assess the presence of the following items, household or conditions in the participant's home. Please note.

<u>Household Assessment</u>

Exterior household status: adequately maintained ____ needs maintenance _____
Interior household status (clean, dirty, cluttered, smoky, crowded, hectic, safe, unsafe, unsanitary, malodorous)
Excluding participant, number of adult household members _______
Excluding participant, number of child (under age 18) household members _______
Excluding participant, number of non-family household members _______
Current living situation (owns, rents, lives with boyfriend/family, halfway home, homeless, other) ________
Type of residence (house, apartment, townhouse, government funded, mobile home, other) _________
Number of bedrooms _______

- ☐ Toilet facilities
- ☐ Household clean/tidy
- ☐ Safe infant sleeping arrangement
- ☐ Pets (cats, dogs, reptiles, rabbits, birds, livestock, other)
- ☐ Vermin
- ☐ Lead hazards
- ☐ Unsafe conditions (of house, in household)
- ☐ Other

Non-functioning items in the household

- ☐ Phone
- ☐ Smoke Detector
- ☐ Running Water
- ☐ Air Conditioner/Fan
- ☐ Heat
- ☐ Refrigerator
- ☐ Stove

Ask the child's parent/guardian if the participant has any interactions with a day care setting, mold in the household, any exposure to second hand smoke, exposure to cat litter, or any other environmental item that could cause a potential illness or risk to the participant. Please note below.

<u>Current Exposures</u>

- ☐ Child Care/Day Care exposure
- ☐ Mold
- ☐ Cat litter
- ☐ Second hand smoke
- ☐ Other

Please note your observation of the interaction between the parent/guardian and child below.

<u>Parent (or Guardian)/Child Interaction</u>

- ☐ Appears to enjoy caring for baby
- ☐ Talks to child in warm, positive tone
- ☐ Responds promptly and calmly to crying
- ☐ Interprets infant cues correctly
- ☐ Holds child close, touches child to comfort
- ☐ Sings or reads to child
- ☐ Positions on stomach to play
- ☐ Positions child on back to sleep
- ☐ Provides consistent routines for eating, sleeping
- ☐ Other

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Through your discussion with child's parent/guardian, please review for any occupational/lifestyle risks. Please check below.
Child's parent/guardian occupational/lifestyle risk

☐ Attending School
-Level of education completed (less than high school, high school, vocational, community college, university)
☐ Employed yes_____ no_____ stay at home mom_____ unable to work due to disability _____
-Type of employment (full time, part time, both)
-Length of employment
-Type of work
☐ Job stress low_____ medium ______ high ______ none _______

Physical/Psychosocial Assessment

Using your observation and interviewing skills, check below your assessment of parent/guardian and child. Define in comments.
***Child's* Physical and Psychosocial Assessment**
Child's age at time of initial assessment ___________ Child's birth weight__________ Child's gestational age_______

☐Age appropriate interaction with others
☐Alert/awake
☐Anxious, fearful
☐Appropriately dressed, clean
☐Confusion, displays lack of understanding
☐Coos/babbles
☐Cuts and bruises
☐Disability
☐Drowsy
☐Irritable, angry, tense
☐Jaundiced
☐Quiet (withdrawn, not talkative, reserved)
☐Restless/agitated
☐Sleeping
☐Swelling
☐Tearful, sad
☐Unkempt, dirty
☐Other

***Parent's or Guardian's* Physical and Psychosocial Assessment**
☐Friendly (talkative, easily engaged in conversation)
☐Quiet (withdrawn, not talkative, reserved)
☐Alert/awake
☐Drowsy
☐Cooperative
☐Uncooperative
☐Limited coping skills (overwhelmed by problems)
☐Confusion, displays lack of understanding
☐Appropriately dressed, clean
☐Unkempt, dirty
☐Restless/agitated

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- ☐ Shaking/tremors
- ☐ Unable to focus, difficulty concentrating, scattered thoughts
- ☐ Tearful, sad
- ☐ Irritable, angry, tense
- ☐ Anxious, fearful
- ☐ Swelling
- ☐ Cuts and bruises
- ☐ Self reported history of mental health diagnosis
- ☐ Disability
- ☐ Other

Risks/Needs/Referrals

Please check below any risk factors identified through the initial assessment process.
These risk factors would be in addition to those previously determined through the initial contact process.
New risk factors identified since initial contact? Yes ______ No ______

Risk Factors

- ☐ Anxiety
- ☐ Household Violence
- ☐ Lack of Car Seat
- ☐ Medical Condition
- ☐ Parent / Guardian does not hold child close or touch child to comfort
- ☐ Sadness
- ☐ Second-hand Smoke
- ☐ Transportation Barriers
- ☐ Unsafe Sleep Environment for infant
- ☐ Other
- ☐ Above checked risk factors discussed with parent/guardian? (Y/N drop down)

Through your discussion with the child's parent/guardian, please determine any current needs of the participant and family. Check below, along with indicating any referrals provided.

New needs identified since initial contact? Yes ______ No ______

Needs Identified	Referrals Provided	Education Provided
☐ Food	________________	________________
☐ Psychosocial/Mental health services	________________	________________
☐ Parenting education	________________	________________
☐ Childbirth education	________________	________________
☐ Nutrition education	________________	________________
☐ Shelter	________________	________________
☐ Clothing	________________	________________
☐ General supplies	________________	________________
☐ School	________________	________________
☐ Employment	________________	________________
☐ Financial assistance	________________	________________
☐ Transportation	________________	________________
☐ Access to Services	________________	________________
☐ Healthcare Coverage	________________	________________
☐ Medical	________________	________________

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☐ Dental ________________
☐ Daycare resources ________________
☐ Baby supplies ________________
☐ Social support ________________
☐ Access to Family Planning ________________
☐ Smoking cessation ________________
☐ Substance abuse treatment ________________
☐ Household Violence Information ________________
☐ Other ________________

Evaluation/Summary

(Health education components below will be on a drop down in HMS for selection)

Health Education Provided

☐ Baby Spacing/Family Planning
☐ Breastfeeding
☐ Disaster/Safety Planning
☐ Immunizations
☐ Infant Care
☐ Medicaid Family Planning Waiver
☐ Nutrition
☐ Parenting
☐ Safe Sleep Environment
☐ Secondhand Smoke
☐ Shaken Baby Prevention
☐ SIDS Risk Reduction
☐ Other (text box)

Care Coordination Details

Method of Initial Assessment: Home Visit _______ Other Face-to-Face Encounter ___________
Client level today ___________________
Plan of care evaluated today? _______________
Plan of care changed today? (text box)________________
Follow-up with provider completed on (date) ____ by ______
Follow-up with provider completed by (method)? Letter _____ Phone_____

Overall Assessment Summary

Signature:____________________________ **Date:_______________**

Authenticate:___________________________ **Date:_______________**

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