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
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.

**Household Assessment**

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.

**Current Exposures**

- 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.

**Parent (or Guardian)/Child Interaction**

- 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
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
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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Name:
ID No:
Date of Birth:

DH 3233, 12/09
☐ 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: ________________________________