Healthy Start
Prenatal/Woman Initial Assessment

Family/Home

Ask the participant what she feels 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 participant what are the family’s main concerns now that the participant is pregnant/postpartum. “Is there anything that is a worry to you right now?” Note below.

Family Concerns

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Through your discussion with the participant, please determine the nutritional practices of the participant. In addition, ask the participant what prescribed medications or over the counter medications the participant is currently taking. Please Note below:

Nutritional Assessment, Medications and Supplements

<table>
<thead>
<tr>
<th></th>
<th>Not Addressed</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving WIC (circle one if applicable)</td>
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<tr>
<td>Special Diet</td>
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<td></td>
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<tr>
<td>Hyperemesis (morning sickness)</td>
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<td></td>
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<tr>
<td>Food allergies</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Meals per day (circle one if applicable)</td>
<td></td>
<td>1  2  3 4 or more</td>
<td></td>
</tr>
<tr>
<td>Type of Fluids (circle all that apply)</td>
<td></td>
<td>milk/water/juice/soda/diet drinks/coffee/tea/alcohol</td>
<td></td>
</tr>
<tr>
<td>Amount</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Raw/undercooked meats/seafood consumed</td>
<td></td>
<td></td>
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<tr>
<td>Amount</td>
<td></td>
<td></td>
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<tr>
<td>PICA (clay, starch, paper, other)</td>
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</tr>
</tbody>
</table>

DH 3234, 12/09
Vitamins/Supplements/Medications
□ Folic Acid/Herbal/Iron/Medications/None/Prenatal
Vitamins/Supplements/Others

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 below.

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 the participant, number of non-family household members _______
Current living situation (owns, rents, lives with boyfriend/family/friends, halfway home, homeless, other) _______
Type of residence (house, apartment, townhouse, government funded, mobile home, other) _______
Number of bedrooms _______

☐ Toilet facilities
☐ 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 participant about any interactions with a day care setting, cleaning used cat litter boxes, mold in the household or workplace, any exposure to second hand smoke, 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
☐ Cat litter
☐ Mold
☐ Second hand smoke
☐ Other

Through your discussion with the participant please review occupational/lifestyle. Please note below.

Participant’s occupation/lifestyle
☐ 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 (radio button-Full time, part time, both)
□ Length of employment
□ Type of work
□ Job stress  low _____ medium _____ high _____ none _______

Physical and Psychosocial Assessment

Using your observation and interviewing skills, check below your assessment of the participant.

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
□ Abused as a child
□ Anxiety
□ Domestic Violence
□ Lack of car seat
Medical condition
Negative feelings about pregnancy or child
Nutritional concern
Sadness
Second-hand smoke
Transportation barriers
Unsafe sleep environment for infant
Other
Above checked risk factors discussed with participant

**Needs Identified and Referrals**

Through your discussion with the participant please determine any current needs of the participant. Check below, along with indicating any referrals provided.

New needs identified since initial contact? Yes _____ No _____

<table>
<thead>
<tr>
<th>Needs Identified</th>
<th>Referrals Provided</th>
<th>Education Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td></td>
<td></td>
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<tr>
<td>Psychosocial/Mental health services</td>
<td></td>
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<tr>
<td>Parenting education</td>
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<tr>
<td>Childbirth education</td>
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<tr>
<td>Nutrition education</td>
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<tr>
<td>Shelter</td>
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<tr>
<td>Clothing</td>
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<tr>
<td>General Supplies</td>
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<tr>
<td>School</td>
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<tr>
<td>Employment</td>
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<tr>
<td>Financial assistance</td>
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<tr>
<td>Transportation</td>
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<tr>
<td>Access to services</td>
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<tr>
<td>Healthcare coverage</td>
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<td>Medical</td>
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<tr>
<td>Dental</td>
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<tr>
<td>Day Care</td>
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<tr>
<td>Baby supplies</td>
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<tr>
<td>Social support</td>
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<tr>
<td>Access to Family Planning</td>
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<tr>
<td>Smoking cessation</td>
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<tr>
<td>Substance abuse treatment</td>
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<tr>
<td>Domestic Violence Information</td>
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<tr>
<td>Other</td>
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</tbody>
</table>

**Evaluation/Summary**

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

**Health Education Provided**

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Name:
ID No:
Date of Birth:

DH 3234, 12/09
Baby Spacing/Family Planning
Breastfeeding
Childbirth
Disaster/Safety Planning
Immunizations
Kick Count
Medicaid Family Planning Waiver
Nutrition
Parenting
Pre Term Labor Danger Signs
Safe Sleep Environment
Secondhand Smoke
Shaken Baby Prevention
SIDS Risk Reduction
Other (text box)

Care Coordinator Evaluation

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: ___________

Name: 
ID No: 
Date of Birth: 

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