



RIGHT FROM THE START PROJECT INITIAL CLIENT ASSESSMENT



***Required Fields**

Prenatal **DEMOGRAPHIC INFORMATION** Infant

*Name: _____
Last First MI

*Address: _____

*County: _____

Telephone Number: _____

Non-Citizen Yes No SSN _____ - _____ - _____

Medicaid No.: _____

HMO: _____ HMO#: _____

RFTS Maternity Services#: _____

*Date of Birth: _____/_____/_____

Employed: Yes No

*Race: White Black/African American Asian
American Indian/Alaska Native
Native Hawaiian/Pacific Islander

*Ethnicity: Hispanic/Latino Not Hispanic/Latino

*Marital Status: Not Married Married Separated
Divorced Other

*OB Provider: _____

Phone: _____

Emergency Contact: _____

Address: _____

Relationship to Client: _____

Phone: _____

Father of Baby: _____ Last First MI Age: _____

Living with Client? Yes No

Monthly Income of Family: _____

Food Stamps: Yes Amount/Month \$ _____ No

Source of Income: _____

Directions to home: _____

*Infant Name: _____
Last First MI

*Address: _____

*County: _____

*Male Female

Telephone Number: _____

SSN _____ - _____ - _____

Medicaid No.: _____

HMO: _____ HMO#: _____

*Birth Facility: _____

*Date of Birth: _____/_____/_____

Birth Score: _____ Apgar Scores:(1min) _____ (5min) _____

*Birth Weight: _____ Gestational Age: _____

*Race: White Black/African American Asian
American Indian/Alaska Native
Native Hawaiian/Pacific Islander

*Ethnicity: Hispanic/Latino Not Hispanic/Latino

*Parent/Guardian: _____

Relationship to Infant: _____

*Pediatrician: _____ Phone: _____

Emergency Contact: _____

Address: _____

Relationship to Client: _____

Phone: _____

Father of Baby: _____ Last First MI Age: _____

Living with Client? Yes No

Monthly Income of Family: _____

Food Stamps: Yes Amount/Month \$ _____ No

Source of Income: _____

Directions to home: _____

MATERNAL MEDICAL INFORMATION

PREGNANCY HISTORY

*Gravida _____ *Para _____ *Abortions: Spontaneous _____ Induced _____

*Past Deliveries: No. of vaginal: _____ No. of C-Sections: _____

Reason: _____

Any Complications? _____

CURRENT PREGNANCY

*EDC: _____ *Initial Prenatal Visit: 1st Trimester 2nd Trimester 3rd Trimester

PRESENT ILLNESS (not related to pregnancy) _____

List current medications, prescription or over the counter: _____

MATERNAL MEDICAL INFORMATION

SERIOUS ILLNESS/CONDITIONS	YES	NO	Comments
1. *Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. *Heart Disease/Defect	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. *Birth Defect	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. *Physical Impairment/Disability	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. *Mental Impairment	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. *High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. *Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. *Stressful Life Event	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. *STDs	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. *History or Risk of Postpartum Depression	<input type="checkbox"/>	<input type="checkbox"/>	Edinburgh Completed : <input type="checkbox"/> Score: _____
11. *Psychiatric History	<input type="checkbox"/>	<input type="checkbox"/>	_____

Past Date: _____ Diagnosis: _____ Present Date: _____ Diagnosis: _____
Therapist/Agency: _____

MATERNAL LEGAL HISTORY (Prenatal/Infant)

CPS Involvement Yes No Self Children Past Current
If minor, who has legal custody of client? _____
Involvement with criminal justice system? Yes No Past Current Self Partner Other
Describe (charges, dates, findings, etc.) _____

Is client on probation? Yes No Probation Worker: _____

EDUCATION (Prenatal)

Presently in school? Yes No Where? _____
*Last grade completed: (Circle) 0 1 2 3 4 5 6 7 8 9 10 11 12 12+ GED Diploma Degree
Special Education History: _____
Education Plans: _____
Employment Goals: _____

INFANT MEDICAL HISTORY

Serious Illness/Conditions:
Respiratory Distress Seizures Hyperbilirubinemia IVH Impairment: Visual Hearing
Congenitally acquired infections:
Herpes Chlamydia Hepatitis HIV Other _____
Sickle Cell Down's Syndrome Cystic Fibrosis Other: _____
*NICU Stay _____(days, weeks, months - circle one) High Risk Clinic Y N
Other health issues: _____

Specialty Physicians: _____

*Breastfeeding? Yes No
Bottle Feeding? Yes Formula Type: _____

INFANT MEDICAL HISTORY (cont'd)

	YES	NO	Comments:
Formula Changes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fluoride Supplement	<input type="checkbox"/>	<input type="checkbox"/>	_____
Started Solid Food	<input type="checkbox"/>	<input type="checkbox"/>	Type/when started: _____
Other Beverages	<input type="checkbox"/>	<input type="checkbox"/>	Type/when started: _____
Feeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diarrhea/Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Use of Medicines	<input type="checkbox"/>	<input type="checkbox"/>	Type/how often: _____
*Technology Dependent	<input type="checkbox"/>	<input type="checkbox"/>	Type: _____
*Newborn Hearing Screen Done	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ Passed: _____ If Failed: L _____ R _____
Date of re screen: _____ Passed: _____ L _____ R _____ If failed re screen, dates referred to Audiologist _____			
Birth to Three _____ ; Sky Hi* _____			

HOUSEHOLD COMPOSITION (Prenatal/Infant)

MEMBERS OF HOUSEHOLD/SUPPORT SYSTEM

Name	Age	Relationship to Client
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHILDREN LIVING OUTSIDE OF HOME

Name	Age	in Custody of
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIVING ARRANGEMENTS

Client's Home/Mobile Home _____	Foster Home _____	Rent Payment \$ Amount: _____
Client's Apartment _____	Shelter _____	House Payment \$ Amount: _____
Public Housing _____	Utilities \$ Amount _____	Other (specify): _____
Parent's Home/Mobile Home _____	Address if other than usual: _____	

HOME/FAMILY ASSESSMENT (Prenatal/Infant)

	YES	NO		YES	NO
*Safe Neighborhood	<input type="checkbox"/>	<input type="checkbox"/>	Need Baby Items	<input type="checkbox"/>	<input type="checkbox"/>
Adequate Space	<input type="checkbox"/>	<input type="checkbox"/>	Specify Items: _____		
Heat Safe/Adequate	<input type="checkbox"/>	<input type="checkbox"/>	Working Fire Extinguisher	<input type="checkbox"/> Observed	<input type="checkbox"/>
Type of Heat _____			Working Smoke Detector	<input type="checkbox"/> Observed	<input type="checkbox"/>
*Environmental Tobacco Smoke	<input type="checkbox"/>	<input type="checkbox"/>	Fire Escape Plan	<input type="checkbox"/>	<input type="checkbox"/>
*CPR Training	<input type="checkbox"/>	<input type="checkbox"/>	Refrigerator	<input type="checkbox"/>	<input type="checkbox"/>
*Transportation	<input type="checkbox"/>	<input type="checkbox"/>	Cooking Facilities	<input type="checkbox"/>	<input type="checkbox"/>
Tub or Shower	<input type="checkbox"/>	<input type="checkbox"/>	Service Providers in Home	<input type="checkbox"/>	<input type="checkbox"/>
Hot Water	<input type="checkbox"/>	<input type="checkbox"/>	*Has Telephone	<input type="checkbox"/>	<input type="checkbox"/>
Type of Water _____ (city, well, cistern, etc.)			Has Washer/Dryer	<input type="checkbox"/>	<input type="checkbox"/>
Toilet Facilities	<input type="checkbox"/>	<input type="checkbox"/>	Pets (explain dangers of cat litter)	<input type="checkbox"/>	<input type="checkbox"/>
Does Client Need Housing Assistance?	<input type="checkbox"/>	<input type="checkbox"/>	Has Emergency Child Care Plan	<input type="checkbox"/>	<input type="checkbox"/>
*Enrolled in WIC	<input type="checkbox"/>	<input type="checkbox"/>	If No, Referral Date _____		
*Safe Crib/Bedding	<input type="checkbox"/>	<input type="checkbox"/>			

POSSIBLE AREAS OF CONCERN (Prenatal/Infant)

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	*Co-Sleeping Risks explained Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Mother's feelings about pregnancy/parenting/infant: <input type="checkbox"/> Unplanned <input type="checkbox"/> Unwanted <input type="checkbox"/> Ambivalent <input type="checkbox"/> Happy
<input type="checkbox"/>	<input type="checkbox"/>	Biological father/partner's feelings about pregnancy/parenting/infant <input type="checkbox"/> Accepting <input type="checkbox"/> Denying <input type="checkbox"/> Rejecting <input type="checkbox"/> Unable to assess
<input type="checkbox"/>	<input type="checkbox"/>	Recent loss of partner <input type="checkbox"/> Abandonment <input type="checkbox"/> Separation/Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other
<input type="checkbox"/>	<input type="checkbox"/>	*Current conflict in home <input type="checkbox"/> Parents <input type="checkbox"/> Partner <input type="checkbox"/> Other Describe: _____
<input type="checkbox"/>	<input type="checkbox"/>	*Dysfunctional family relations
<input type="checkbox"/>	<input type="checkbox"/>	*Any experience with abuse in the past year <input type="checkbox"/> Physical <input type="checkbox"/> Verbal <input type="checkbox"/> Sexual <input type="checkbox"/> Other Describe: _____ Referral made to _____ Client refused <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Religious/ethnic/cultural factors affecting pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	≥ 2 preschool children
<input type="checkbox"/>	<input type="checkbox"/>	Poor/ineffective demonstrated parenting skills
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with budgeting money/food stamps
<input type="checkbox"/>	<input type="checkbox"/>	Handicapped/disabled member of household Who _____
<input type="checkbox"/>	<input type="checkbox"/>	*Illiteracy <input type="checkbox"/> Self <input type="checkbox"/> Partner
<input type="checkbox"/>	<input type="checkbox"/>	Non-compliant with need for prescribed Tx <input type="checkbox"/> Self <input type="checkbox"/> Children <input type="checkbox"/> Other
<input type="checkbox"/>	<input type="checkbox"/>	*Smoker # CPD _____ Date SCRIPT presented _____
<input type="checkbox"/>	<input type="checkbox"/>	*Second hand smoke exposure
<input type="checkbox"/>	<input type="checkbox"/>	*Alcohol/Drug use Describe _____ Referral made to _____ Client refused <input type="checkbox"/>

ENHANCED SERVICES - NUTRITIONAL

	YES	NO
1. Medical condition requiring dietary modification	<input type="checkbox"/>	<input type="checkbox"/>
2. Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>
3. Non-food cravings: Type: _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Frequently skips meals/fast/binge (circle)	<input type="checkbox"/>	<input type="checkbox"/>
5. *History of bulleimia/anorexia	<input type="checkbox"/>	<input type="checkbox"/>
6. Food allergy/intolerance	<input type="checkbox"/>	<input type="checkbox"/>
7. *Prior nutritional counseling	<input type="checkbox"/>	<input type="checkbox"/>
8. *Dental impairment affecting adequacy of diet	<input type="checkbox"/>	<input type="checkbox"/>
Referrals: _____	Date: _____	
_____	Date: _____	

ENHANCED SERVICES - PARENT/PREVENTIVE SELF CARE/CHILDBIRTH EDUCATION

	YES	NO
1. Poor previous pregnancy experience	<input type="checkbox"/>	<input type="checkbox"/>
2. Significant apprehension/anxiety	<input type="checkbox"/>	<input type="checkbox"/>
3. Poor pregnancy information	<input type="checkbox"/>	<input type="checkbox"/>
4. Lack of knowledge of risk factors	<input type="checkbox"/>	<input type="checkbox"/>
5. Lack of knowledge for prescribed treatment	<input type="checkbox"/>	<input type="checkbox"/>
6. Unrealistic expectations for infant	<input type="checkbox"/>	<input type="checkbox"/>
7. Desires parenting/infant care education	<input type="checkbox"/>	<input type="checkbox"/>
8. Non-stimulating environment for infant	<input type="checkbox"/>	<input type="checkbox"/>
9. Desires childbirth education	<input type="checkbox"/>	<input type="checkbox"/>
Referrals: _____	Date: _____	
_____	Date: _____	

OTHER REFERRALS NOT LISTED ABOVE

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

DCC Signature and Title: _____ *Date: _____

Name of DCC Agency: _____ *County _____

☆A Signed Copy must be sent to RCC