OFFICE OF MATERNAL, CHILD AND FAMILY HEALTH
RIGHT FROM THE START PROGRAM
**INITIAL CLIENT ASSESSMENT – INFANT**

## DEMOGRAPHICS

Name: Last First MI | Date of Birth: (mm/dd/yyyy) | Male ☐ | Female ☐

Address: Street City State Zip Code

County of Residence: Telephone #: Alternative Telephone #:

Current Address (if not living at home): Street City State Zip Code

Directions to Home:

Birth Score: ☐ High ☐ Low ☐ Unknown

Birth Facility:

Race (check one):
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Multi Race/Other
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Ethnicity (check one):
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino

Caretaker Name: Last First MI

Relationship to Infant (check one): ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Other Family ☐ Other, please specify: _____

## RFTS HISTORY

Is/was mother of infant enrolled in The Right From The Start Program as a prenatal client (check one)? ☐ Yes ☐ No ☐ Unknown
If yes, total number of maternal enrollments: _____
If yes, and applicable, previous name: _____
Are/were any other family in the household (e.g. siblings, cousins) enrolled in the Right From the Start Program? ☐ Yes ☐ No
If yes, total number of familial enrollments: _____

## PRENATAL

In what month was client's initial prenatal visit? Month # _____ ☐ None ☐ Unknown
How many prenatal appointments has the client attended? _____ appointments
Mother used supplements during pregnancy (check all that apply)? ☐ Folic acid ☐ Prenatal/Multivitamins ☐ Unknown
Frequency of supplement use (check one): ☐ 2 or fewer times per week ☐ 3 or 4 times per week ☐ 5 or more times per week ☐ Irregularly
While pregnant, did mother of infant use/was exposed to any substances (check one)? ☐ Yes ☐ No ☐ Unknown
If yes, what substance(s)? (check all that apply)
☐ Stimulants (cocaine, methamphetamine) ☐ Depressants (barbiturate, benzodiazepine) ☐ Hallucinogens (ecstasy, LSD, ketamine) ☐ Opioids (hydrocodone, codeine, buprenorphine, oxycodone, morphine, heroin) ☐ Marijuana ☐ Caffeine ☐ Mercury ☐ Pesticides ☐ Alcohol ☐ Nicotine (tobacco products, vape) ☐ Other drugs, please specify: _____
Does anyone in the client's household (parent, sibling, etc.) use substances (excluding caffeine, mercury, pesticides)? ☐ Yes ☐ No
If yes, who and what substances: _____
High-risk pregnancy (check one)? ☐ Yes ☐ No ☐ Unknown
Was this birth a (check one): ☐ Singleton birth ☐ Multiple (#): ____ ☐ Unknown
If a multiple birth, did this pregnancy also result in (check one): ☐ Miscarriage (> 20 weeks) ☐ Stillborn (< 20 weeks) ☐ Live birth ☐ Unknown
Pregnancy notes: _____

## FEEDING/BREASTFEEDING

Has the infant ever breastfed (including breastmilk supplemented with formula; check one)? ☐ Yes ☐ No ☐ Unknown
Is/was the infant ever exclusively breastfed (check one)? ☐ Yes ☐ No ☐ Unknown
If yes, how long has the infant exclusively breastfed? _____ months
If no or unknown, is infant currently fed formula exclusively? ☐ Yes ☐ No
If eating solid food, at what age did infant start (includes cereal mixed in bottle; check one)? ☐ 0-3 months ☐ 4-6 months ☐ 7-12 months ☐ Unknown
Does infant have difficulty feeding: from bottle? ☐ Yes ☐ No
from breast? ☐ Yes ☐ No
If mother was advised not to breastfeed, reason (check one): ☐ Medical reasons ☐ Substance use ☐ Unknown

If breastfeeding stopped, what were the reasons why (check all that apply):

- ☐ Infant had difficulty latching or nursing
- ☐ Breast milk alone did not satisfy the baby
- ☐ Infant was not gaining enough weight
- ☐ Mother's nipples got sore, cracked or bleeding
- ☐ It was too hard, painful or too time consuming
- ☐ Infant was jaundiced
- ☐ Substance use
- ☐ Other: _____
- ☐ Mother was not producing enough milk/her milk dried up
- ☐ Mother had too many other household duties
- ☐ Mother felt it was the right time to stop breastfeeding
- ☐ Mother became sick and had to stop for medical reasons
- ☐ Mother went back to work or school
- ☐ Infant was living with another caretaker not mother
- ☐ Discouragement from friends/family
- ☐ Unknown

## LABOR AND DELIVERY

Birth weight: _____ pounds _____ ounces Gestational Age: _____ (weeks)

Birth length: _____ inches

Delivery Type (check one): ☐ Vaginal ☐ Scheduled C-section ☐ Emergency C-Section ☐ VBAC ☐ Unknown

Were there any maternal complications during labor and delivery? ☐ Yes ☐ No ☐ Unknown

If yes, list: _____

Special conditions at birth (check all that apply):

☐ Fetal Alcohol Spectrum Disorder (FASD) ☐ Neonatal Abstinence Syndrome ☐ Substance Exposed Infant (excluding caffeine, mercury, pesticides) ☐ Other, specify: _____

## HEALTH REVIEW

Does infant have a medical home? ☐ Yes ☐ No

Primary location for child's regular medical checkups and sick care (check one):

☐ Doctor's/nurse practitioner's office ☐ Hospital emergency room ☐ Hospital outpatient
☐ Federally qualified health center ☐ Retail store or minute clinic ☐ Unknown/did not report ☐ None
☐ Other (please specify): _____

Has infant kept all recommended well child visits with primary care provider, up to current age (check one)? ☐ Yes ☐ No ☐ Unknown

Did client attend the following recommended dates of well-child visits (check all that apply):

☐ 5 days ☐ 1 month ☐ 2 months ☐ 4 months ☐ 6 months ☐ 9 months ☐ 12 months

Immunizations up to date (check one)? ☐ Yes ☐ No ☐ Unknown Date last received immunizations: _____

If not up to date, please specify why not: _____

## ORAL HEALTH

Infant has access to dental care? ☐ Yes ☐ No

Infant had his/her first dental appointment? ☐ Yes ☐ No

Has the infant's medical care provider had a conversation with the caretaker about age one (1) dental visit? ☐ Yes ☐ No

Does infant have any teeth at case opening? ☐ Yes ☐ No

Does infant have fluoride exposure via drinking water, supplements, professional applications or toothpaste? ☐ Yes ☐ No

Does infant drink/eat sugary foods i.e. juice, carbonated or non-carbonated soft drinks, energy drinks? ☐ Yes ☐ No

Did caretaker receive infant oral health education by RFTS provider? ☐ Yes ☐ No

Is brushing teeth, flossing, and/or cleaning gums a part of the child's daily routine? (check one): ☐ Always ☐ Sometimes ☐ Never

Does infant fall asleep with a bottle? (check one): ☐ Always ☐ Sometimes ☐ Never

Does guardian have concerns about the child's teeth or gums? ☐ Yes ☐ No

If yes, please specify concerns about the teeth or gums: _____

## DCC USE ONLY

## DETAILED HEALTH REVIEW

Medical conditions (check all that apply):

- ☐ Acquired immunodeficiency syndrome (AIDS)
- ☐ Asthma and respiratory allergies
- ☐ Cancer
- ☐ Cerebral palsy
- ☐ Congenital heart disease
- ☐ Cystic fibrosis
- ☐ Diabetes
- ☐ Digestion disorders
- ☐ Down syndrome
- ☐ Emotional/mental health disorders
- ☐ Feeding difficulties in early childhood
- ☐ Genetic disorders
- ☐ Hearing impairment
- ☐ Heart disease/defects
- ☐ Human immunodeficiency virus (HIV)
- ☐ Jaundice
- ☐ Juvenile arthritis
- ☐ Overweight and obesity
- ☐ Prematurity and low birth weight
- ☐ Sickle cell anemia/disease
- ☐ Spina bifida/neural tube defects
- ☐ Visual impairment
- ☐ Other (please specify): _____

Developmental conditions (check all that apply):

- ☐ Acquired brain injury and selected neurological disorders
- ☐ Sensory processing disorder
- ☐ Motor delay and movement disorders
- ☐ Other (please specify): _____

Allergies (check all that apply):
☐ Environmental ☐ Food ☐ Medicines ☐ Other (please specify): _____

Medicines and supplements taken regularly (check all that apply):
☐ Over-the-counter drugs ☐ Ear drops ☐ Vitamin supplements ☐ Antibiotics ☐ Eye ointment
☐ Asthma inhalers ☐ Other (please specify): _____

According to the health care provider, is child's size and weight OK? ☐ Yes ☐ No
If no, please specify concerns about child's size or weight: _____

Child has been screened for anemia? ☐ Yes ☐ No ☐ Unknown
If yes, please specify results of anemia screening: _____

Child has been screened for lead levels? ☐ Yes ☐ No ☐ Unknown
If yes, please specify results of lead screening: _____

## SAFETY REVIEW

There is at least one working smoke detector on each floor where the family resides. ☐ Yes ☐ No
Family has a plan and supplies in case of an emergency in the home or natural disaster. ☐ Yes ☐ No
Do you have any concerns about your physical living space that impact well-being or safety? ☐ Yes ☐ No
If yes, please specify: _____

## EMERGENCY AND MEDICAL CONTACTS

| Pediatrician: | Phone #: |
|---|---|

| Name of Emergency Contact: | Relationship to Client: | Phone #: |
|---|---|---|

Address: Street City State Zip Code

## SUPPORT SYSTEM

**Other parent of infant:** Last First MI Age ☐ Living with client

**Other caregiver of infant:** Last First MI Age ☐ Family ☐ Friend ☐ Partner

**Other household members**

| Name | Age | Relationship to client: |
|---|---|---|
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**Children Living Outside the Home**

| Name | Age | In custody of: |
|---|---|---|
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| | | |
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| | | |

## NOTES

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|---|---|---|---|---|
| **DCC Signature:** | **Title:** | **Agency:** | **Region:** | **Date:** |

**Sign, then copy both sides of each sheet; original to DCC Agency and copy to RCC.**