OFFICE OF MATERNAL, CHILD AND FAMILY HEALTH
RIGHT FROM THE START PROGRAM
INITIAL CLIENT ASSESSMENT – ☐ PRENATAL ☐ POSTPARTUM

DEMOGRAPHICS				
Name: Last	First	MI	Date of Birth: (mm/dd/yyyy)	Age:
Address: Street	City	State	Zip Code	
County of Residence:	Telephone #:	Email Address:		
Current Address: (if not staying at home) Street	City	State	Zip Code	
Directions to Home:				

Race (check one):	Ethnicity (check one):	Marital Status (check one):	
☐ American Indian or Alaskan Native	☐ Hispanic/Latino	☐ Divorced	☐ Married
☐ Asian	☐ Not Hispanic/Latino	☐ Never Married	☐ Not Married, But Living Together
☐ Black/African American		☐ Separated	☐ Unknown
☐ Multi Race/Other		☐ Widowed	
☐ Native Hawaiian or Other Pacific Islander			
☐ White			

EDUCATION, HOUSING & EMPLOYMENT

Current education level (check one):
☐ Less than high school diploma ☐ High school diploma ☐ High school equivalency ☐ Some college/training ☐ Technical training program
☐ Associate's degree ☐ Bachelor's degree or higher ☐ Unknown/prefer not to answer

Is client currently in foster care? ☐ Yes ☐ No

Current housing status (check one):
☐ Homeless and sharing housing ☐ Homeless and living in an emergency or transitional center ☐ Homeless, in some other living arrangement
☐ Lives in public housing ☐ Lives with parent or other family member ☐ Not Homeless, in some other living arrangement
☐ Rents or shares own home or apartment ☐ Owns or shares own home, condominium, or apartment

Is the client currently employed? ☐ Yes ☐ No If yes, ☐ Full-time ☐ Part-time

Was client previously enrolled in RFTS? ☐ Yes ☐ No If yes, previous number of enrollments: _____
If yes, and applicable, previous name: _____

HEALTH CARE

What is the client's source of health insurance? ☐ Medicaid ☐ Maternity Services

Does client have a medical home (i.e. primary care physician)? ☐ Yes ☐ No | Does client have a dental home? ☐ Yes ☐ No

How often does client go to dental appointments? ☐ Every 6 months ☐ Every year ☐ Less than annually ☐ Never

Has client ever been diagnosed with a mental illness or psychiatric disorder? ☐ Yes ☐ No
If yes, please specify: _____

SUBSTANCE USE

Before client found out she was pregnant, did she use/was she exposed to:
☐ Stimulants (cocaine, methamphetamine) ☐ Depressants (barbiturate, benzodiazepine) ☐ Hallucinogens (ecstasy, LSD, ketamine)
☐ Opioids (hydrocodone, codeine, oxycodone, morphine, heroin) ☐ Marijuana ☐ Caffeine ☐ Mercury ☐ Pesticides
☐ Nicotine (tobacco products, vape) ☐ Medication Assisted Treatment (Suboxone, Methadone, Vivitrol, etc.) ☐ Alcohol

After client found out she was pregnant, did she use/was she exposed to:
☐ Stimulants (cocaine, methamphetamine) ☐ Depressants (barbiturate, benzodiazepine) ☐ Hallucinogens (ecstasy, LSD, ketamine)
☐ Opioids (hydrocodone, codeine, oxycodone, morphine, heroin) ☐ Marijuana ☐ Caffeine ☐ Mercury ☐ Pesticides
☐ Nicotine (tobacco products, vape) ☐ Medication Assisted Treatment (Suboxone, Methadone, Vivitrol, etc.) ☐ Alcohol

Is the client **currently** using any of the following?
☐ Stimulants (cocaine, methamphetamine) ☐ Depressants (barbiturate, benzodiazepine) ☐ Hallucinogens (ecstasy, LSD, ketamine)
☐ Opioids (hydrocodone, codeine, oxycodone, morphine, heroin) ☐ Marijuana ☐ Caffeine ☐ Mercury ☐ Pesticides
☐ Nicotine (tobacco products, vape) ☐ Medication Assisted Treatment (Suboxone, Methadone, Vivitrol, etc.) ☐ Alcohol

Is client currently in treatment for substance use?
If yes, what type of treatment (check all that apply)?
☐ Individual/Group Counseling ☐ Inpatient/Residential Treatment ☐ Medication Assisted Treatment ☐ Recovery Support Services
☐ Other, please specify: _____

Does anyone in the client's household (partner, parent, sibling, etc.) use substances (excluding caffeine, mercury, pesticides)? ☐ Yes ☐ No
If yes, who and what substances: _____

PREGNANCY INFORMATION (PRENATAL ONLY)

Estimated Date of Delivery (mm/dd/yyyy):	Estimated Weeks Pregnant:	High-risk pregnancy? ☐ Yes ☐ No

Client: _____

In what month was client's initial prenatal visit? Month # _____ ☐ None If none, was referral made? ☐ Yes ☐ No	How many prenatal appointments has the client attended? _____ appointments
Client uses supplements (check all that apply)? ☐ Folic acid ☐ Prenatal/Multivitamins	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

LABOR AND DELIVERY (POSTPARTUM ONLY)

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: _____

DCC USE ONLY

DETAILED PREGNANCY HISTORY

Gravida:	Para:	Total # of Abortions:		# Living Children:
		Spontaneous:	Induced:	

Complications with Past Deliveries:

Present Illness (non-pregnancy related):

Current Medications (prescription or OTC):

MEDICAL HISTORY: Have you ever been diagnosed with…

Illness/Disease	Yes	No	Assistance Needed/Comments
Diabetes?	☐	☐	
Gestational diabetes?	☐	☐	
Heart disease/defect?	☐	☐	
Birth defect?	☐	☐	
Physical impairment/disability?	☐	☐	
Any STIs?	☐	☐	
High/Low blood pressure?	☐	☐	
Seizures?	☐	☐	
Intellectual impairment/disability?	☐	☐	
Had any past surgery(ies)?	☐	☐	

NUTRITION ASSESSMENT

Issues	Yes	No	Assistance Needed/Comments
Have medical condition requiring dietary medication?	☐	☐	
Have nausea/vomiting?	☐	☐	
Have non-food craving? (If yes, list below)	☐	☐	
List:			
Frequently skips meals/fasts/binges?	☐	☐	
Have an eating disorder or history?	☐	☐	
Have a food allergy or intolerance?	☐	☐	
Have prior nutritional counseling?	☐	☐	

ORAL HEALTH

Issues	Yes	No	Assistance Needed/Comments
History of oral health problems?	☐	☐	
Painful aching in mouth in past year?	☐	☐	
Do you have a toothbrush and toothpaste/floss?	☐	☐	

CHILDBIRTH EDUCATION/PREVENTIVE SELF-CARE

Issues	Yes	No	Assistance Needed/Comments
Lack of knowledge of risk factors?	☐	☐	

Lack of knowledge of prescribed treatments?	☐	☐	
Non-compliance with prescribed treatments?	☐	☐	
HOME/FAMILY NEEDS ASSESSEMENT			
Issues	**Yes**	**No**	**Assistance Needed/Comments**
Have emergency plan?	☐	☐	
Have pets (explain danger of cat litter)?	☐	☐	
Are there other in-home providers? (If yes, list below)	☐	☐	
List:			
Client literacy level? ☐ Functional/A degree of comprehension	☐	☐	
Religious/ethnic/cultural factors affecting pregnancy outcomes?	☐	☐	
Family member(s) with disabilities?	☐	☐	
Any concerns about the physical living space that impact well-being or safety (if yes, please specify)?	☐	☐	
Concerns:			
LEGAL HISTORY			
Issues	**Yes**	**No**	**Assistance Needed/Comments**
CPS Involvement? ☐ Past ☐ Current ☐ Self ☐ Children	☐	☐	
Involvement with criminal justice system? ☐ Past ☐ Current ☐ Self ☐ Partner	☐	☐	

MEDICAL AND EMERGENCY CONTACTS		
OB Provider Name:	Telephone:	
Emergency Contact Name:	Telephone:	Relationship to client:
Street City State Zip Code Emergency Contact Address:		
SUPPORT SYSTEM		
Last First MI Age **Other parent of infant:**		☐ Living with client
Last First MI Age **Other caregiver of infant:**		☐ Family ☐ Friend ☐ Partner

Other household members		
Name	Age	Relationship to client
Children living outside the home		
Name	Age	In custody of
NOTES		

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

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