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

DEMOGRAPHICS

Name: (Last, First, MI) | Date of Birth: (mm/dd/yyyy) | Age:

Address: (Street, City, State, Zip Code)

County of Residence: | Telephone #: | Alternative Telephone #:

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

Directions to Home:

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

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

Marital Status (check one):
- ☐ Divorced
- ☐ Married
- ☐ Never Married
- ☐ Not Married, But Living Together
- ☐ Separated
- ☐ Unknown
- ☐ Widowed

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 the client found out she was pregnant, did she use alcohol? ☐ Yes ☐ No
If yes, in the 3 months before client was pregnant, how many alcoholic drinks did she have in an average week (check one)?
☐ Less than 1 ☐ 1 to 3 ☐ 4 to 7 ☐ 8 to 13 ☐ 14 +

After the client found out she was pregnant, did she use alcohol? ☐ Yes ☐ No
If yes, in the time since the client knew she was pregnant, how many alcoholic drinks did she have in an average week (check one)?
☐ Less than 1 ☐ 1 to 3 ☐ 4 to 7 ☐ 8 to 13 ☐ 14 +

Before client found out she was pregnant, did she use/was she exposed to any substances? ☐ Yes ☐ No
If yes, in the 3 months before client was pregnant, 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
☐ Nicotine (tobacco products, vape) ☐ Other drugs, please specify: _____

After client found out she was pregnant, did she use/was she exposed to any substances? ☐ Yes ☐ No
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
☐ Nicotine (tobacco products, vape) ☐ Other drugs, please specify: _____

Is client currently in treatment for substance use? ☐ Yes ☐ No
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: _____

Client: _____

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

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

In what month was client's initial prenatal visit?	How many prenatal appointments has the client attended?
Month # _____ ☐None If none, was referral made? ☐Yes ☐No	_____ 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

PREGNANCY HISTORY

Number of Past Deliveries? Vaginal:_____ Scheduled C-Section: _____ Emergency C-Section: _____ VBAC: _____
Reason for C-Section: _____

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.