***** EPDS , Audit, DAST, PICCOLO *****

HSID: __ __ __ __ - __ __ __ __ - 00 Date: ___ /___ /_____ Staff_____

Location of Visit ☐ Home ☐Office ☐ Other

Core Data Questions
Highest level of Education Completed?
☐ No formal schooling
☐ Less than 8th grade
☐ Less than high school diploma
☐ High School graduate
☐ GED completed
☐ Some college/formal training beyond high school
☐ Technical training/ trade school or certification
☐ Associate's degree
☐ College (Bachelor's degree)
☐ Graduate Degree
☐ Other
☐ Don't Know
☐ Declined to answer

Currently a Student or in Training? ☐ Yes ☐ No

Employment Status
☐ Full Time
☐ Part Time < 30 hours per week
☐ Not Employed

Total Household Income (yearly): _____

Adults (18 yrs+): _____

Children (17 or younger): _____

Total in Household: system generates using the sum of the number of adults + child(ren) in the household

Income Category: will populate in system if total in household information is entered
 50% and under
 51% - 100%
 100% - 133%
 134% - 200%
 201% - 300%
 >300%
 Unknown

Income level: will populate in system if total in household information is entered
 < 100% FPL
 100%-185% FPL
 >185% FPL
 Unknown

Housing Status
 Not Homeless
 Homeless
 Unknown/ Did not report

Homeless Situation
 Homeless and sharing housing
 Homeless and living in emergency or transitional shelter
 Homeless with some other arrangement

_____End of Core Data Questions_____

Mother's First Name: _____ Mother's Child's Last Name: _____
Youngest Child's Name_____ Youngest Child's Age: _____

☐ Change Client Contact Information (Update if needed)
Current Address_____Phone_____ ☐ None
City_____ State_____ Zip Code_____
County_____

Mother's enrollment status (auto-populated). Prenatal Postpartum

Year of enrollment_____

Client's Current Age: _____ If <age 24, meets CSHCN criteria? ☐ Yes ☐ No

Are you currently pregnant? ☐ No, continue ☐ Yes, **STOP-** (Exit this ID number. Enter as new Prenatal client with new Healthy Start ID number)

Primary Insurance Coverage: ☐ Medicaid ☐ MI-Child ☐ Private. ☐ None

Medical Home. ☐ Yes ☐ No

HRSA/AHRQ Definition of medical home: "The primary medical home is accountable for meeting the majority of the patients physical and mental health care needs (Prevention, wellness, acute & chronic care); is relation based & oriented toward the whole person, coordinate care across the broader system of specialty care, hospitals home health & community services/supports, is accessible and committed to quality and safety."

Medical Home Description: ☐ Tribal Clinic ☐ Private Practice
☐ Hospital Based Primary Care Center ☐ Community Health Center (other than tribe

Have you had an annual checkup visit to your primary care provider in the last 12 months?
☐ Yes ☐ No

Child Date of Birth (or date most recent pregnancy ended): ____/____/____
# of Mos. Postpartum: ____.

Last Pregnancy ended in: ☐ Live birth ☐ Miscarriage ☐ Fetal death (20 plus weeks)

Transportation

Do you have reliable transportation? ☐ Yes ☐ No

If Yes, please describe (drop down):

☐ Own Car
☐ Borrow Car
☐ Gets rides from family
☐ Gets rides from friends/others
☐ Public transport adequate

BMI Calculation: Feet_____ Inches: _____ Weight: _____ BMI: co___ System generated_

Vitals	Values	Results	Follow Up: Action taken
Blood Pressure (BP)		☐WNL ☐ Outside NL	
Temp		☐WNL ☐ Outside NL	
Pulse		☐WNL ☐ Outside NL	
Respiration		☐WNL ☐ Outside NL	
Other, Specify_____		☐WNL ☐ Outside NL	

Physical Activity:
In the past 30 days have you participated in any leisure time physical activity, such as walking, biking, swimming or other sports, etc.? ☐ Yes ☐ No

In an average week, how often do you participate in at least 30 minutes of physical activity?
☐ zero times ☐ once ☐ 2-3 times ☐ 4 times ☐ 5 or more

Medical Conditions	**Have been treated for or told that you have**	**Date of last visit to health care provider about this condition**	**Follow up needed? Y/N**
Asthma	☐ Yes ☐ No		☐ Yes ☐ No
Recurring Vag Infections	☐ Yes ☐ No		☐ Yes ☐ No
Sexually transmitted infection:	☐ Yes ☐ No		☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No		☐ Yes ☐ No
Hepatitis B or C	☐ Yes ☐ No		☐ Yes ☐ No
Hypertension	☐ Yes ☐ No		☐ Yes ☐ No
High cholesterol	☐ Yes ☐ No		☐ Yes ☐ No
Diabetes: Non-insulin dependent Insulin dependent Gestational (if hx of GDM ask about BS screen)	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No		☐ Yes ☐ No
Family Hx Breast Cancer	☐ Yes ☐ No		☐ Yes ☐ No
Family Hx of Other Cancer:	☐ Yes ☐ No		☐ Yes ☐ No
Oral Health Issues	☐ Yes ☐ No		☐ Yes ☐ No
Mental Illness: depression, bipolar, other	☐ Yes ☐ No		☐ Yes ☐ No
Other:	☐ Yes ☐ No		☐ Yes ☐ No

Dental Care:
Last dental exam and cleaning within the past: ☐ 1 year ☐ 1-2 yrs. ☐ 3-5 yrs. ☐ 5yrs+/don't know

Breastfeeding (any) Duration: _____ months enter 0,1,2, etc. (If on-going at 1 yr. postpartum, enter 12)

Family Planning:
Are you currently using a method of birth control? ☐ Yes ☐ No ☐ Refused
Are you currently trying for another pregnancy? ☐ Yes ☐ No ☐ Refused
Do you need additional information or assistance to obtain birth control?
☐ Yes ☐ No ☐ Refused

Smoking:

Do you currently smoke cigarettes? ☐ Yes ☐ No ☐ Refused
About how many do you smoke per day? _____
Have you cut down in the past year? ☐ Yes ☐ No ☐ Refused
Are you seriously considering quitting? ☐ Yes ☐ No ☐ Refused

Parenting Education Classes:
Have you ever attended a parenting class? ☐ Yes ☐ No ☐ Refused
Would you like to receive parenting education at this time? ☐ Yes ☐ No ☐ Refused

EPDS Screening: (POP-OUT) ☐ Yes Score: Auto-populates ☐ Not completed

Domestic Violence:

During the past 12 months has anyone?	Current of former Intimate Partner	Other Family Member	Someone else	No-One	Declined to answer
Threatened you or made you feel unsafe in some way	☐	☐	☐	☐	☐
Made you feel frightened for your safety or your family's safety because of their anger or threats?	☐	☐	☐	☐	☐
Tried to control your daily activities, for example, control who you could talk to for where you could go?	☐	☐	☐	☐	☐
Pushed, hit, slapped, kicked, choked, or physically hurt you in any other way?	☐	☐	☐	☐	☐
Forced you to take part in touching or any sexual activity when you didn't want to ?	☐	☐	☐	☐	☐

Staff- Indicate IPV screening status below
☐ Screening completed (all questions answered)
☐ Screening not completed due to:
☐ Presence of partner
☐ Presence of family member or friend
☐ Participant declined to answer one or more questions
☐ Other reason. Please Specify_____

Alcohol Use: *One drink = 12 oz./1 can of Beer, 5 oz. wine, 1.5 oz. liquor (one shot)

How many times in the past year have you had 4 or more drinks in a day?
☐ None ☐ 1 or more (Proceed to AUDIT screen) ☐ Refused

Drug Use:

Are you in treatment for Alcohol, Drug, or Substance Use? ☐ Yes ☐ No ☐ Refused
If yes, skip "Alcohol and Drug Use" questions below

How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons? (not prescribed for you)
☐ None. ☐ 1 or more (Proceed to DAST screen) ☐ Refused

*Recreational drugs include Methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalents (paint thinner, aerosol, glue), tranquilizers (Valium, Xanax), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

Basic Needs

In the last 12 months, did you (or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food? ☐ Yes ☐ No ☐ Refused

How often did this happen?
☐Almost every month ☐Some months but not every month ☐In only 1 or 2 months

Do you receive a Bridge Card (food Stamps)? ☐ Yes ☐ No

How many times have you moved in the past 12 months? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Do you currently have any concerns or worries about you housing situation? ☐ Yes ☐ No

If Yes what are your concerns or worries about your housing? (Check all that apply)

Instability

☐ Eviction or being forced to move out
☐ Affordability of current house or apartment
☐ No place to live, no regular nighttime residence
☐ Strained relations with others in household

Adequacy

☐ House or apartment is too crowded
☐ Lack of continuous functioning basic utility service (e.g. heat, electricity)

Safety

☐ Safety of house/apartment
☐ Safety of neighborhood

How often do you have access to a telephone to make and receive calls?

☐ Always ☐ Sometimes ☐ Never

Work/Education Hours:

About how many (awake) hours per week do you dedicate to the following activities
Working outside the home_____. Caring for your infant/child_____.
Obtaining Education (ie. Diploma/GED/Highschool/formal training/job training/ college/cultural and community education programs/study time.)_____

PICCOLO Scores:

Affection:_____ Responsiveness_____ Encouragement_____ Teaching_____

Notes: