

***** PHQ9, Audit, DAST, PICCOLO, PFS(optional)*****

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)		<input type="checkbox"/> WNL <input type="checkbox"/> Outside NL	
Temp		<input type="checkbox"/> WNL <input type="checkbox"/> Outside NL	
Pulse		<input type="checkbox"/> WNL <input type="checkbox"/> Outside NL	
Respiration		<input type="checkbox"/> WNL <input type="checkbox"/> Outside NL	
Other, Specify _____		<input type="checkbox"/> WNL <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Recurring Vag Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sexually transmitted infection:	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes: Non-insulin dependent Insulin dependent Gestational (if hx of GDM ask about BS screen)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Hx Breast Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Family Hx of Other Cancer:	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Oral Health Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Illness: depression, bipolar, other	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> 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 2 yr. postpartum, enter 24)

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

PHQ9 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Made you feel frightened for your safety or your family's safety because of their anger or threats?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tried to control your daily activities, for example, control who you could talk to for where you could go?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pushed, hit, slapped, kicked, choked, or physically hurt you in any other way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forced you to take part in touching or any sexual activity when you didn't want to ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 _____

Protective Factors Survey (Pop-Out) (optional)

- Yes Not completed

Notes: