POSTPARTUM 2 YEAR ASSESSMENT

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

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

Current Income Information. (Only count income that supports the whole family)

***Total Household Income (yearly)** ____

***Adults (18 yrs+):** ____ ***Children (17 or younger):** ____ ***Total in 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 (go to Homeless Situation Below)
□ 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_____

Address Information
Any changes to the client contact information must be done on the Enter Edit form.

Current Address_____
City_____ State_____ County_____
ZipCode_____ Phone_____ ☐ None

Mother's Information

Mother's First Name: _____ Mother's Last Name: _____

Mother'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)

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

Breastfeeding

Are you still breastfeeding? ☐ Yes ☐ No ☐ Refused/Unknown

Duration of Breastfeeding (months) _____

If still breastfeeding, enter the child's current age.

If breastfeeding has ended, enter the child's age (in months) when breastfeeding stopped.

Food

*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, How often did this happen?

☐Almost every month ☐Some months but not every month☐In only 1 or 2 months

☐ No

☐ Refused

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

Transportation

*Do you have access to reliable transportation? ☐ Yes ☐ No

If No, please check all concerns that apply

☐ Potential Unavailability

☐ Unreliable

☐ Not affordable

*Needs transportation assistance

☐ Yes ☐ No

Housing

*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 your housing situation? ☐ Yes ☐ No

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

☐ No place to live, no regular nighttime residence

☐ Eviction or being forced to move out

☐ Affordability of current house or apartment

☐ Safety of house/apartment

☐ Strained relations with others in household

☐ Sanitation/Waste Removal

☐ House or apartment is too crowded

☐ Pest Control

☐ Safety of neighborhood

☐ Ease of access into home

☐ Code Violations

☐Ventilation/Air Conditioning

☐ Lack of continuous functioning basic utility service (e.g. heat, electricity)

Telephone

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

☐ Always ☐ Sometimes ☐ Never

Physical Activity: BMI Calculation: Feet_____ Inches: _____ Weight: _____ BMI: ___

*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

Oral Health

How long has it been since you had a dental exam and cleaning?

☐ Within the past year

☐ Within the past 2 years

☐ Within the past 5 years

☐ More than 5 years

☐ Don't know/not sure

☐ Never

Medical

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	

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
Group B Strep or Bacterial Vaginosis	☐ Yes ☐ No		☐ Yes ☐ No
Recurring Vaginal 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
Fecal Occult blood test (FOBT)/colon cancer screening	☐ Yes ☐ No		☐ Yes ☐ No
Oral Health Issues	☐ Yes ☐ No		☐ Yes ☐ No
Mental Illness: depression, bipolar, other	☐ Yes ☐ No		☐ Yes ☐ No
Other:			

Specify	☐ Yes ☐ No		☐ Yes ☐ No

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

Substance Use

*Are you currently in treatment for alcohol, drug, or substance use? ☐ Yes ☐ No ☐ Refused

Alcohol Use (AUDIT)
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

AUDIT (Alcohol Use Disorder Identification Test)

1.How often do you have a drink containing alcohol?
(0) Never
(1) Monthly
(2) 2-4 times a month
(3) 2-3 times a week
(4) or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1-2
(1) 3 or 4
(2) 5 or 6
(3) 7-9
(4) 10 or more

3. How often do you have six or more drinks in one occasion?
(0) Never
(1) Less than Monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

4. How often during the last year have you found that you were unable to stop drinking once you started?
(0) Never
(1) Less than Monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected of you because of drinking?
(0) Never
(1) Less than Monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
(0) Never
(1) Less than Monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you felt guilt or remorse after drinking?
(0) Never
(1) Less than Monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because of drinking?
(0) Never
(1) Less than Monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as the result of your drinking?
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you quit?

(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Total AUDIT Score:_____(system generated)

_____End of Audit Screening_____

Drug Use:

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

*In the past year have you used illicit drugs?
☐ Yes (Proceed to DAST screen) ☐ No ☐ Refused

*In the past year have you used marijuana?
☐ Yes (Proceed to DAST screen) ☐ No ☐ Refused

*In the past year have you used prescription medication for non-medical reasons?
☐ Yes (Proceed to DAST screen) ☐ No ☐ Refused

DAST 10

1. Have you used drugs other than those required for medical reasons?
(1)Yes
(0)No

2. Do you abuse more than one drug at a time?
(1)Yes
(0)No

3. Are you always able to stop using drugs when you want to?
(1)Yes
(0)No

4. Have you ever had blackouts or flashbacks as a result of drug use?
(1)Yes
(0)No

5. Do you ever feel bad or guilty about your drug use?
(1)Yes

(0)No

6. Does your spouse (or parents) ever complain about your involvement with drugs?
(1)Yes
(0)No

7. Have you neglected your family because of your use of drugs?
(1)Yes
(0)No

8. Have you engaged in illegal activities in order to obtain drugs?
(1)Yes
(0)No

9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
(1)Yes
(0)No

10. Have you had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding)?
(1)Yes
(0)No

TOTAL DAST SCORE_____ (system generated)

_____End of DAST_____

DEPRESSION (PHQ9)

*PHQ9 Screening: ☐ Yes ☐ Not completed, Specify_____

PATIENT HEALTH QUESTIONAIRE (PHQ-9)
Over the last two weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
(0) Not at all
(1) Several days
(2) More than half the days
(3) Nearly every day

2. Feeling down, depressed, or hopeless
(0) Not at all
(1) Several days
(2) More than half the days
(3) Nearly every day

3. Trouble falling or staying asleep, or sleeping too much

(0) Not at all
(1) Several days
(2) More than half the days
(3) Nearly every day

4. Feeling tired or having little energy

(0) Not at all
(1) Several days
(2) More than half the days
(3) Nearly every day

5. Poor appetite or overeating

(0) Not at all
(1) Several days
(2) More than half the days
(3) Nearly every day

6. Feeling bad about yourself or that you are a failure or have let yourself or your family down

(0) Not at all
(1) Several days
(2) More than half the days
(3) Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

(0) Not at all
(1) Several days
(2) More than half the days
(3) Nearly every day

8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual

(0) Not at all
(1) Several days
(2) More than half the days
(3) Nearly every day

9. Thoughts that you would be better off dead, or of hurting yourself

(0) Not at all
(1) Several days
(2) More than half the days
(3) Nearly every day

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐Not difficult at all

☐Somewhat difficult

☐Very difficult

☐Extremely difficult

Total PHQ9 Score_____(system generated)

*** Staff: Please indicate which response best reflects the need for referral and/or follow-up services related to possible depression.**

☐ Participants total score was less than 10 and so did not indicate a need for referral

☐ Participants total score of 10 or more indicates that additional screening and referral is needed, and referral was provided

☐ Participants total score of 10 or more indicates that additional screening and referral is needed, but referral was not provided because client is already receiving services for possible depression

☐ Participant's total score of 10 or more indicates that additional screening and referral is needed, but referral was not provided because client declined referral

Stress (Perceived Stress Scale)

*** In the last month, how often have you felt that you were unable to control the important things in your life?**

☐ Never (0)

☐ Almost Never (1)

☐ Sometimes (2)

☐ Fairly Often (3)

☐ Very Often (4)

*** In the last month, how often have you felt confident about your ability to handle your personal problems?**

☐ Never (4)

☐ Almost Never (3)

☐ Sometimes (2)

☐ Fairly Often (1)

☐ Very Often (0)

*** In the last month, how often have you felt that things were going your way?**

☐ Never (4)

☐ Almost Never (3)

☐ Sometimes (2)

☐ Fairly Often (1)

☐ Very Often (0)

*** In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?**

☐ Never (0)

☐ Almost Never (1)

☐ Sometimes (2)

☐ Fairly Often (3)

☐ Very Often (4)

Higher Score, Higher the stress

Total Perceived Stress Score_____(system generated)

Abuse/ Violence:

Are you in a relationship now? ☐ Yes ☐ No ☐ Refused

Do you feel safe in your present relationship? ☐ Yes ☐ No ☐ Refused

*Have you ever been involved with Children's Protective Services with any of your children?

☐ Yes ☐ No ☐ Refused

***During the past 12 months has anyone….**

*a.Threatened you or made you feel unsafe in some way

☐Current of former Intimate Partner

☐Other Family Member

☐Someone else

☐No-One

☐Declined to answer

*b.Made you feel frightened for your safety or your family's safety because of their anger or threats?

☐Current of former Intimate Partner

☐Other Family Member

☐Someone else

☐No-One

☐Declined to answer

*c.Tried to control your daily activities, for example, control who you could talk to for where you could go?

☐Current of former Intimate Partner
☐Other Family Member
☐Someone else
☐No-One
☐Declined to answer

*d.Pushed, hit, slapped, kicked, choked, or physically hurt you in any other way?
☐Current of former Intimate Partner
☐Other Family Member
☐Someone else
☐No-One
☐Declined to answer

*e.Forced you to take part in touching or any sexual activity when you didn't want to ?
☐Current of former Intimate Partner
☐Other Family Member
☐Someone else
☐No-One
☐Declined to answer

*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_____

Protective Factors Survey

☐Yes ☐Not completed

FFR	SS:	CS:

NA.	CDKP	Total:

1. In my family, we talk about problems.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

2. When we argue, my family listens to “both sides of the story”.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

3. In my family, we take time to listen to each other.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

4. My family pulls together when things are stressful.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

5. My family is able to solve our problems.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

6. I have others who will listen when I need to talk about my problems.

(1) Never
(2) Very Rarely

(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

7. When I am lonely, there are several people I can talk to.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

8. I would have no idea where to turn if my family needed food or housing.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

9. I wouldn't know where to go for help if I had trouble making ends meet.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

10. If there is a crisis, I have others I can talk to.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

11. If I needed help finding a job, I wouldn't know where to go for help.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently

(7) Always

12. There are many times when I don't know what to do as a parent.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

13. I know how to help my child learn.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

14. My child misbehaves just to upset me.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

15. I praise my child when he/she behaves well.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

16. When I discipline my child, I lose control.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

17. I am happy being with my child.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently

18. My child and I are very close to each other.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

19. I am able to soothe my child when he/she is upset.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

20. I spend time with my child doing what he/she likes to do.

(1) Never
(2) Very Rarely
(3) Rarely
(4) About half the time
(5) Frequently
(6) Very Frequently
(7) Always

Notes: