

Name
 Birth date
 I.D. number
 EDD

COMPREHENSIVE PERINATAL SERVICES PROGRAM

INITIAL COMBINED ASSESSMENT

PERSONAL INFORMATION

1. Your name: _____
2. Age: Less than 12 years 12–17 years 18–34 years 35 years or older
3. Place of birth: _____
4. How long have you lived in this area? Less than 1 year 1–5 years 5+ years Life
5. Do you plan to stay in this area for the rest of your pregnancy? Yes No
6. Are you: Married Single Divorced/separated Widowed Other: _____
7. Who lives with you in your home?

Name	Relation	Age	Name	Relation	Age

8. Do any of your children or your partner's children live with someone else? Yes No N/A
 If yes, explain: _____

ECONOMIC RESOURCES

9. Are you currently working? Yes No If yes, type of work and hours per week: _____
10. Do you plan to return to work after the baby is born? Yes No
11. Will the father of the baby provide financial support to you and the baby? Yes No
12. Are you receiving any of the following: (Check all that apply.)

	Yes	No	Needs Information/Referral
a. WIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Food stamps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. AFDC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Emergency food assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Pregnancy-related disability insurance benefits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Do you have enough clothes for yourself and your family? Yes No
14. Do you or others in your home skip meals due to lack of money? Yes No

HOUSING

15. What type of housing do you currently live in?
 Apartment House Hotel/motel Emergency shelter Public housing
 Trailer park Car Farm worker camp Other: _____

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16. Do you have the following where you live? (Check all that apply.)

	Yes	No		Yes	No		Yes	No
Tub/shower	<input type="checkbox"/>	<input type="checkbox"/>	Stove	<input type="checkbox"/>	<input type="checkbox"/>	Telephone	<input type="checkbox"/>	<input type="checkbox"/>
Electricity	<input type="checkbox"/>	<input type="checkbox"/>	Heat	<input type="checkbox"/>	<input type="checkbox"/>	Hot water	<input type="checkbox"/>	<input type="checkbox"/>
Refrigerator	<input type="checkbox"/>	<input type="checkbox"/>	Toilet	<input type="checkbox"/>	<input type="checkbox"/>	Cold water	<input type="checkbox"/>	<input type="checkbox"/>

17. Do you feel your current housing meets your basic needs? Yes No

18. Do you feel safe in your home? Yes No

If no, why not? _____

19. If there are guns in your home, how are they stored? _____

TRANSPORTATION

20. Will you have problems keeping your appointments? Yes No

If yes, is the problem: Transportation Child care Work School Other: _____

21. When you ride in a car, how often do you use seat belts? Always Sometimes Never

22. Will you be able to get a car safety seat for the new baby by the time it is born? Yes No

CURRENT HEALTH PRACTICES

23. Have you ever had trouble finding a doctor or getting necessary treatment for yourself or your family? Yes No

If yes, please explain: _____

24. Have you been to the dentist in the last year? Yes No

25. What do you do for exercise? _____ How often? _____

26. Since you became pregnant have you used any over-the-counter medications? Yes No

If yes, what? _____ How much? _____ How often? _____

27. Since you became pregnant have you used any prescription medications? Yes No

If yes, what? _____ How much? _____ How often? _____

28. In your home, how do you store: Vitamins _____

Medications _____ Cleaning agents _____

29. Do you have exposure to chemicals:

a. At work? Yes No If yes, what? _____

b. At home? Yes No If yes, what? _____

c. With hobbies? Yes No If yes, what? _____

PREGNANCY CARE

30. Was this pregnancy planned? Yes No

31. How do you feel about being pregnant now? _____

32. Are you considering: Adoption? Yes No Abortion? Yes No

33. How does the father of the baby feel about this pregnancy? _____

a. Your family? _____

b. Your friends? _____

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34. Do you have any of the following problems now? (Check all that apply.)

	Yes	No		Yes	No
a. Swelling of hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	h. Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
b. Constipation	<input type="checkbox"/>	<input type="checkbox"/>	i. Backache	<input type="checkbox"/>	<input type="checkbox"/>
c. Fatigue/sleeping problems	<input type="checkbox"/>	<input type="checkbox"/>	j. Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
d. Vaginal discharge/bleeding	<input type="checkbox"/>	<input type="checkbox"/>	k. Nausea	<input type="checkbox"/>	<input type="checkbox"/>
e. Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	l. Headaches	<input type="checkbox"/>	<input type="checkbox"/>
f. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	m. <input type="checkbox"/> Other _____		
g. Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>			

35. In comparison to your previous pregnancies, is there anything you would like to change about the care you receive?
 Yes No N/A Please explain: _____

36. Do you have any traditional, cultural, or religious customs about pregnancy and childbirth you would like supported?
 Yes No Please explain: _____

37. Who gives you the most advice about your pregnancy? _____

38. What have you been told that you think is important? _____

39. Do you use any natural or herbal remedies (example: ginseng, manzanilla, greta, magnesium, yerba buena)?
 Yes No If yes, what and how often: _____

40. Do you plan to have someone with you:
a. During labor? Yes No Do not know
b. When you first come home with the baby? Yes No Do not know

41. If you had a baby before, where was that baby(s) delivered?
 Hospital Clinic Home Other _____
Were there any problems? Yes No
If yes, please explain: _____

42. Have you had any losses in past pregnancies such as:

	Yes	No		Yes	No		Yes	No
Miscarriages	<input type="checkbox"/>	<input type="checkbox"/>	Adoption	<input type="checkbox"/>	<input type="checkbox"/>	Abortion	<input type="checkbox"/>	<input type="checkbox"/>
Stillborn	<input type="checkbox"/>	<input type="checkbox"/>	SIDS	<input type="checkbox"/>	<input type="checkbox"/>			

If yes, what/who helped you get through this? _____

43. If you have had other children, are they still living? Yes No N/A
If no, please explain: _____

44. Besides having a healthy baby, what are your goals for this pregnancy? _____

45. Do you plan to use a method of birth control after this pregnancy? Yes No Undecided
If yes, what method: Birth control pill Diaphragm Norplant IUD
 Foam and/or condoms Natural Family Planning Abstinence Sterilization Depoprovera

46. Have you ever had a sexually transmitted infection, such as gonorrhea, syphilis, chlamydia, herpes? Yes No
a. If yes, what and when: _____
b. Has your partner had a sexually transmitted infection? Yes No Do not know

47. Information given on HIV transmission, risk reduction behavior modification, methods to reduce the risk of perinatal transmission; counseling and referral to other HIV prevention and psychosocial services as needed; and referral for HIV testing. Yes No Initials: _____

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NUTRITION

48. Anthropometric data: (Complete the following.) Height _____ Current weight _____ Date _____
 Prepregnancy weight _____ Normal Underweight Overweight Very overweight
 Weight gain goal _____ Net weight gain _____ Adequate Inadequate Excessive
 Weight gain in previous pregnancies: lbs _____ Unknown N/A Weight grid plotted
49. Biochemical data: (Complete the following.)
 Blood: Date _____ Hgb/Hct _____ MCV _____ Glucose Screen _____
 Urine: Date _____ (Circle) Glucose + - Ketones + - Protein + -
50. Clinical data: (Indicate if any of the following apply.)
 Short pregnancy interval Anemia Diabetes: Prepregnancy Past pregnancy
 Serious infection Dental disease Hypertension: Prepregnancy Past pregnancy
 Hx low birth weight baby High parity (>4) Currently breastfeeding
 Age 17 years or less Digestive problems Hx intrauterine growth retardation
 Other medical/obstetrical problems: Past _____ Current _____
51. Do you take prenatal vitamins? Yes No Do you take iron? Yes No Other? Yes No
52. How would you describe your appetite? Good Fair Poor
Do you sometimes feel you can't stop eating? Yes No
53. Have your eating habits changed since you became pregnant? Yes No
If yes, please explain: _____
54. How many times per day do you usually eat? _____
Do you have questions or concerns about your weight and/or weight gain during pregnancy? Yes No
If yes, please list: _____
55. Have you had cravings for or eaten any of the following? (Circle all that apply.) Yes No
laundry starch freezer frost cornstarch clay paste plaster dirt other _____
56. Do you have any food allergies? Yes No If yes, please explain: _____
Are there any foods or beverages you avoid? Yes No If yes, please explain: _____
57. Are you on a special diet? Yes No
If yes, what kind? Weight loss Low salt Low fat/cholesterol Vegetarian Diabetic
 Other: _____
58. If vegetarian, do you eat: Milk and dairy products Fish/chicken Eggs
59. How many cups of the following do you drink in a day? _____ regular coffee _____ regular tea _____ sodas
60. Who usually does the following in your home? Buys food: _____ Prepares food: _____
61. Dietary intake: (check all that apply)
- | | | | | | |
|---------------|------------------------------------|-------------------------------------|--|---|-------------------------------|
| LOW | <input type="checkbox"/> Vitamin A | <input type="checkbox"/> Vitamin C | <input type="checkbox"/> Other fruits and vegetables | <input type="checkbox"/> Bread/grain/cereal | |
| | <input type="checkbox"/> Protein | <input type="checkbox"/> All groups | <input type="checkbox"/> Fluid | <input type="checkbox"/> Milk | <input type="checkbox"/> Iron |
| EXCESS | <input type="checkbox"/> Fat | <input type="checkbox"/> Sugar | <input type="checkbox"/> Salt | <input type="checkbox"/> High Kcal. | |

INFANT FEEDING

62. If you have other children, did you breastfeed, or try to breastfeed them? Yes No N/A
Did you have trouble breastfeeding? Yes No How long did you breastfeed? _____
63. How are you planning to feed your new baby?
 Breast Formula Both breast and formula Other: _____ Do not know

WIC REFERRAL

Provider signature

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COPING SKILLS

64. In the past month, how often have you felt that you could not control the important things in your life?
Have you felt that way: very often often sometimes rarely never
65. What things in your life do you feel good about? _____
66. Are you currently having any of these problems: (Check all that apply.)
- | | Yes | No | | Yes | No |
|---------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|
| a. Financial difficulties | <input type="checkbox"/> | <input type="checkbox"/> | f. Unemployment | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Housing problems | <input type="checkbox"/> | <input type="checkbox"/> | g. Immigration | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Divorce/separation | <input type="checkbox"/> | <input type="checkbox"/> | h. Legal | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Recent death | <input type="checkbox"/> | <input type="checkbox"/> | i. Probation/parole | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Illness | <input type="checkbox"/> | <input type="checkbox"/> | j. Child Protective Services | <input type="checkbox"/> | <input type="checkbox"/> |
67. What things in your life would you like to change? _____
68. What do you do when you are upset? _____
69. What do you and your partner do when you have disagreements? _____
70. Do you ever feel afraid or threatened by your partner? Yes No
If yes, please explain: _____
71. Within the last year have you been hit, slapped, kicked, or physically hurt by someone? Yes No
If yes, please explain: _____
72. Have you ever been a victim of violence and/or sexual abuse? Yes No
73. Have your children ever been victims of violence and/or sexual abuse? Yes No
74. Have your parents been victims of violence and/or sexual abuse? Yes No
75. Do you ever get depressed? Yes No
76. Have you ever felt so bad you planned or attempted suicide? Yes No
77. Have you ever talked to a counselor? Yes No
If yes, please explain: _____
78. Would you feel comfortable talking to a counselor if you had a problem? Yes No

TOBACCO, DRUG, AND ALCOHOL USE

79. Do you smoke cigarettes? Yes No
If yes, how many cigarettes per day? _____ for how many years? _____
80. Are you exposed to secondhand smoke at home or at work? Yes No
81. Are you using chewing tobacco? Yes No
82. If you smoke cigarettes or chew tobacco, have you:
 Considered quitting Set a definite date to quit Decided to cut down Decided not to quit at this time
83. How often do you drink alcohol (beer, wine, wine coolers, hard liquor, mixed drinks)?
 Daily Weekends 1-2 times per month Rarely or never

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84. Have your alcohol habits changed since you got pregnant? Yes No
 If yes how? _____
85. Are you interested in stopping or cutting down while you are pregnant? Yes No
86. Have you ever used street drugs (marijuana, cocaine, PCP, crack, speed, crank, ice, heroin, LSD, other)? . Yes No
 a. If yes, what: _____ How often? _____
 b. Are you interested in quitting? Yes No
87. If your partner uses drugs or alcohol, does this create problems for you? Yes No

EDUCATION AND LANGUAGE

88. Years of education completed: 0–8 years 9–11 years 12–16 years 16+ years
 a. Are you currently enrolled in school? Yes No N/A
 b. Will you return to school after the baby is born? Yes No N/A
89. What language do you prefer to speak: English Other _____
90. What language do you prefer to read: English Other _____
91. Which of the following best describes how you read:
 Like to read and read often Can read but do not read often Do not read

EDUCATIONAL INTERESTS

92. Do you have experience with or have you received education in any of the following topics in the past (Column A—Do you know about?), or would like additional information during this pregnancy (Column B—Would you like more information?); both columns may be marked:

TOPIC	COLUMN A Have Previous Experience/ Do You Know About?	COLUMN B Would You Like More Information?
How your baby grows (fetal development)		
How your body changes during pregnancy		
Healthy habits for a healthy baby		
What you should eat while you are pregnant		
Gaining weight in pregnancy		
What happens during labor and delivery		
What you need to know about preterm (premature) labor		
Hospital tour		
How to take care of yourself after the baby comes		
Breastfeeding		
Infant feeding		
Circumcision		
Helping your other children get ready for the new baby		
Information about car seats/passenger safety		
How to take care of your baby and keep it safe		

