

COMPREHENSIVE PERINATAL SERVICES PROGRAM

Name
 Birth date
 I.D. number
 EDD

INITIAL COMBINED ASSESSMENT (Annotated)

PERSONAL INFORMATION

- Your name: _____
Serves as a formal identifier in addition to providing an opportunity to determine how the client prefers to be addressed.
- Age: Less than 12 years 12–17 years 18–34 years 35 years or older
Shaded responses typically will require additional referrals: teens may be at high risk medically in addition to possible referral to AFLP/CAL LEARN; older women may need additional genetic evaluation. Refer to “Steps To Take” (STT) Guidelines: Psychosocial–Teen Pregnancy and Parenting.
- Place of birth: _____
May give some indication as to the client’s cultural background.
- How long have you lived in this area? Less than 1 year 1–5 years 5+ years Life
Individuals who have lived in an area for a short while may be less familiar with community resources and have a weaker support system.
- Do you plan to stay in this area for the rest of your pregnancy? Yes No
If the client does not intend to remain in the area she will need assistance in arranging for transfer of her care and counselling on the value of adequate prenatal care.
- Are you: Married Single Divorced/separated Widowed Other: _____
The response may give some indication of the client’s support system.
- Who lives with you in your home?

Name	Relation	Age	Name	Relation	Age

This response should include all the people she lives with, not just a nuclear family. The response will give you some idea of the client’s support system, the reality of her home environment (especially important when considering referrals) and an opportunity to personalize your care by being able to refer to family members by name. Response to this question may be facilitated by having the patient complete this information on a separate piece of paper in the waiting room which can be copied into the chart.

- Do any of your children or your partner’s children live with someone else? Yes No N/A
 If yes, explain: _____
A “yes” response may give some indication of her parenting skills if children have been formally removed from the home. Children left behind as a result of migration to this country may result in grief issues. See STT Guidelines: Psychosocial–Parenting Stress, New Immigrant.

ECONOMIC RESOURCES

- Are you currently working? Yes No If yes, type of work and hours per week: _____
“Work” refers to paid efforts that can occur outside the home or within (child care, laundry, sewing, etc.). This information will help the assessor understand the economic resources of the family in addition to possible health risks for the client. It also provides an opportunity to discuss how long she plans to work. See STT Guidelines: Health Education–Workplace and Home Safety.
- Do you plan to return to work after the baby is born? Yes No
If yes, this is an opportunity to discuss child care plans and make referrals to community resources as appropriate.

11. Will the father of the baby provide financial support to you and the baby? Yes No
In addition to adding another piece to the client's economic picture, it also gives some indication of the father's involvement. Consider not just dollar support, but groceries, transportation, etc.
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 checked="" 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"/>

All clients on CPSP should be eligible for WIC and should be referred. The other items need to be individually evaluated. For assistance in making these referrals, see STT Guidelines: Psychosocial–Financial Concerns.

13. Do you have enough clothes for yourself and your family?
If no, see STT Guidelines: Psychosocial–Financial Concerns, for suggestions of resources.
14. Do you or others in your home skip meals due to lack of money?
If yes, keep this in mind when assessing nutritional status and also see STT Guidelines: Psychosocial–Financial Concerns, and Nutrition–Stretching Your Food Dollar, for suggestions.

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: _____

Shaded responses are usually indicative of inadequate housing or transiency and can have serious impact on the client's health and well-being. Suggestions for referral resources can be found in STT Guidelines: Psychosocial–Financial Concerns.

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 checked="" type="checkbox"/> | Stove | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Telephone | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Electricity | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Heat | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Hot water | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| Refrigerator | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Toilet | <input type="checkbox"/> | <input checked="" type="checkbox"/> | Cold water | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

Lack of items identified in shaded responses are important to know when providing instruction regarding personal care and nutritional counseling. Lack of a telephone may have important ramifications on the client's ability to report potential complications (preterm labor, urinary tract infection, bleeding, etc.); alternate methods of communication should be identified prior to their need. See also: STT Guidelines: Nutrition–Cooking and Food Storage.

17. Do you feel your current housing meets your basic needs? Yes No
Although previous questions should give the assessor a general sense of the adequacy of the client's home, this question permits the client to make her own assessment. What may seem inadequate to the assessor may not be a problem for the client.
18. Do you feel safe in your home? Yes No
 If no, why not? _____
Again, this question provides the client with an opportunity to express her own concerns and needs. In this case, "safety" refers to the environment (substandard housing, gang activity, drug-dealing, etc.) rather than domestic violence.
19. If there are guns in your home, how are they stored? _____
Guns should be kept in locked storage, preferably with trigger locks. This question may also include discussion about other dangerous weapons such as knives.

TRANSPORTATION

- 20. Will you have problems keeping your appointments? Yes No
 If yes, is the problem: Transportation Child care Work School Other: _____
Important information to consider when making medical and support service appointments and for referrals.
- 21. When you ride in a car, how often do you use seat belts? Always Sometimes Never
An opportunity to determine if a discussion of the importance and proper use of seat belts is needed.
- 22. Will you be able to get a car safety seat for the new baby by the time it is born? Yes No
If no, this is an opportunity to determine if education is needed regarding the CA Carseat Safety laws and make referrals to local resources. See also STT Guidelines: Health Education–Infant Safety and Health.

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: _____
Difficulties with the health care system in the past may impact how the client perceives her current care and how she responds to referrals.
- 24. Have you been to the dentist in the last year? Yes No
If no, assist client to arrange dental care (see your provider’s application for dental resources). Poor dental health can seriously impact the pregnant woman from chronic infection to impaired eating ability.
- 25. What do you do for exercise? _____ How often? _____
Regular exercise can give the client a sense of well-being and relaxation. For suggestions and cautions regarding exercise in pregnancy, see STT Guidelines: Health Education–Safe Exercise and Lifting.
- 26. Since you became pregnant have you used any over-the-counter medications? Yes No
 If yes, what? _____ How much? _____ How often? _____
If yes, this is an opportunity to instruct the client on the hazards of OTC medications, and an opportunity to evaluate the need for medical evaluation of the condition for which she uses OTC’s. For additional suggestions see STT Guidelines: Health Education–Drug and Alcohol Use.
- 27. Since you became pregnant have you used any prescription medications? Yes No
 If yes, what? _____ How much? _____ How often? _____
If yes, see question 26 and make sure the medical provider is aware of this information.
- 28. In your home, how do you store: Vitamins _____
 Medications _____ Cleaning agents _____
All medications, even seemingly “mild” medications such as as vitamins and iron, should be stored in a secure location, such as a locked cabinet, if there are children in the home. Purses are not considered secure. Cleaning agents should be stored in their original containers, away from food, and secure from children. Plan the client’s education according to her safety knowledge and habits.
- 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? _____*If yes, see STT Guidelines: Health Education–Workplace and Home Safety.*

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
Questions 30, 31, and 32 will provide the assessor with information about the client’s feelings regarding this pregnancy. For the client who is still ambivalent and/or considering adoption or abortion, refer to STT Guidelines: Psychosocial–Unwanted Pregnancy, for suggestions.

33. How does the father of the baby feel about this pregnancy? _____
- a. Your family? _____
- b. Your friends? _____

Responses to these questions will provide the assessor with information regarding the client's support system and stressors she may be facing.

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"/>			

Evaluate "yes" responses on the basis of practice protocols. If appropriate for the assessor, many of these conditions can be addressed by suggestions as outlined in STT Guidelines: Nutrition.

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: _____

"Yes" answers provide assessor with information about past care that was not helpful to client so that these issues can be avoided with this pregnancy (if possible).

36. Do you have any traditional, cultural, or religious customs about pregnancy and childbirth you would like supported?

Yes No Please explain: _____

Acknowledgement and support of cultural and religious customs important to the client will result in a client who will participate in her care. In some cases these customs may be in conflict with medical care, and it is important to evaluate these situations with the medical provider. For additional suggestions see STT Guidelines: First Steps—Cultural Considerations.

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

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

Questions 37 and 38 will identify who should also be involved in the client's care. It will be very difficult to provide perinatal education if your information conflicts with this person's advice.

39. Do you use any natural or herbal remedies (example: ginseng, manzanilla, greta, magnesium, yerba buena)?

Yes No If yes, what and how often: _____

Herbal remedies need to be evaluated for potential harmful effects on the fetus.

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

If the client cannot identify a support person for labor, the assessor should begin to explore possible resources for both the labor period and childbirth preparation classes. If no support in the immediate postpartum period, this is an opportunity to help the client explore who will be available to help her care for herself, the newborn, including breastfeeding, and other children, if any. See STT Guidelines: Psychosocial—Parenting Stress.

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: _____

An opportunity to identify problems and plan to avoid them with this pregnancy and/or identify positive experiences to draw upon.

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? _____
The client may have unresolved grief issues that can impact this pregnancy and the care of the newborn. It also identifies some strengths that may be helpful in addressing current issues. For additional suggestions see STT Guidelines: Psychosocial–Perinatal Loss.

43. If you have had other children, are they still living? Yes No N/A

If no, please explain: _____
Again, identifies possible unresolved grief issues and/or fears that may affect this pregnancy. See also question 42.

44. Besides having a healthy baby, what are your goals for this pregnancy? _____
An empowerment opportunity for the client. With assistance from the assessor, the client may be able to use this opportunity to make personal changes in her life, rather than focusing in on only a goal of “a healthy baby.”

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
Each client should have the opportunity to make a fully informed decision about what method, if any, she wants to use postpartum. See STT Guidelines: Health Education–Family Planning Choices, for suggestions.

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: _____
Current state regulations require that all pregnant women, not just those who are at risk, receive counseling on the benefits of HIV testing and pregnancy, treatments available to women who test positive, and referral for HIV testing. This item permits the provider/practitioner to document that they have provided the woman the required services. For additional suggestions on providing HIV education, see STT Guidelines: Health Education–HIV and Pregnancy.

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

This information helps determine weight gain goals for the pregnancy and necessary nutritional education. STT Guidelines can provide assistance in helping the assessor complete the weight gain grid and determining weight gain goals. Women who begin pregnancy underweight or overweight may need more comprehensive nutrition care.

49. Biochemical data: (Complete the following.)
 Blood: Date _____ Hgb/Hct _____ MCV _____ Glucose Screen _____
 Urine: Date _____ (Circle) Glucose + - Ketones + - Protein + -
Abnormal values need to be brought to the medical provider’s attention and a plan developed to address needs.

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 _____
All of the above information has important implications in developing a nutritional care plan for the client. Site specific protocols should be reviewed to determine appropriate care, STT Guidelines: Nutrition–Prenatal Vitamin and Minerals, Iron and Calcium, can also offer suggestions for appropriate education and referrals.

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
Requires additional probing to determine if the client has concerns about or is experiencing an eating disorder.
53. Have your eating habits changed since you became pregnant? Yes No
 If yes, please explain: _____
Provides additional context to her response to question 52. It is important to know that a client's appetite was poor before she became pregnant vs. the client whose appetite changed as a result of pregnancy.
54. How many times per day do you usually eat? _____
Permits the assessor to develop nutritional recommendations that "fit" with the client's usual habits.
 Do you have questions or concerns about your weight and/or weight gain during pregnancy? Yes No
 If yes, please list: _____
Permits assessor to emphasize an appropriate weight gain goal. See STT Guidelines: Nutrition–Weight Gain During Pregnancy.
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 _____
"Yes" answers require evaluation to determine the extent of the problem and need for referral to the medical provider. Additional suggestions are in STT Guidelines: Nutrition–Pica, Possible Problems From Pica.
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: _____
Requires evaluation as to impact on appropriate perinatal diet. See STT Guidelines: Nutrition–Lactose Intolerance, for additional suggestions.
57. Are you on a special diet? Yes No
 If yes, what kind? Weight loss Low salt Low fat/cholesterol Vegetarian Diabetic
 Other: _____
Requires evaluation as to impact on perinatal nutritional needs and development of client specific nutritional education. May also require referral for medical nutrition therapy.
58. If vegetarian, do you eat: Milk and dairy products Fish/chicken Eggs
Not all individuals define "vegetarian" in the same way. This question identifies the specifics of your client's vegetarian diet.
59. How many cups of the following do you drink in a day? _____ regular coffee _____ regular tea _____ sodas
General fluid intake is important for proper metabolic functioning. The specific beverages imbibed can indicate sources of excess sugars or caffeine. High diet soda intake may be as a result of a fear of having a larger baby and a perceived more difficult birth.
60. Who usually does the following in your home? Buys food: _____ Prepares food: _____
This information will provide the assessor with some indication as to the control the client has over what food is purchased and how it is prepared.
61. Dietary intake: (check all that apply)
- | | | | | |
|---------------|------------------------------------|-------------------------------------|--|---|
| | <input type="checkbox"/> Vitamin A | <input type="checkbox"/> Vitamin C | <input type="checkbox"/> Other fruits and vegetables | <input type="checkbox"/> Bread/grain/cereal |
| LOW | <input type="checkbox"/> Protein | <input type="checkbox"/> All groups | <input type="checkbox"/> Fluid | <input type="checkbox"/> Milk |
| | <input type="checkbox"/> Iron | <input type="checkbox"/> Fiber | | |
| EXCESS | <input type="checkbox"/> Fat | <input type="checkbox"/> Sugar | <input type="checkbox"/> Salt | <input type="checkbox"/> High Kcal. |
- Excess: fat, sugar, salt, 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? _____
Provides an opportunity to build on previous positive experiences and/or evaluate difficulties and provide education to support breastfeeding. For additional suggestions, see STT Guidelines: Nutrition–Breastfeeding reference.
63. How are you planning to feed your new baby?
 Breast Formula Both breast and formula Other: _____ Do not know
All women should be provided basic breastfeeding information so they can make an informed decision. The client who plans to give both breast and formula may be inadvertently sabotaging her breastfeeding efforts and probably needs additional assistance in clarifying her decision. See STT Guidelines: Health Education–Infant Feeding Decision-Making.

WIC REFERRAL

Provider signature _____

Date _____

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
This question permits the client to give her evaluation of her emotional status. Shaded responses should be further explored to determine if this is a long-standing issue or more related to the emotional swings of early pregnancy.
65. What things in your life do you feel good about? _____
Provides that assessor with an opportunity to build on positives in the client's life.
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"/> |
- Any "yes" responses can provide stress for the client. Suggestions for referrals can be found in STT Guidelines: Psychosocial–Financial Concerns, Legal/Advocacy Concerns, New Immigrant, Depression.*
67. What things in your life would you like to change? _____
Provides information on patient hopes and values. Changes that can be attached to these values have a higher probability of success.
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
Questions 67–73 help the assessor determine the potential and/or presence of domestic violence in the client's relationships. Interventions should be based on legal mandates and practice specific protocols. Additional information is available in STT Guidelines: Psychosocial–Spousal/Partner Abuse.
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
Provides information on patient's history of serious mental illness and what range of referrals might be possible. For additional information, see STT Guidelines: Psychosocial–Emotional or Mental Health Concerns, Depression.

TOBACCO, DRUG, AND ALCOHOL USE

79. Do you smoke cigarettes? Yes No
 If yes, how many cigarettes per day? _____ for how many years? _____
It is important to document carefully the client's smoking history, not just whether she smokes or not. Interventions for someone who smokes one–two cigarettes/week are likely to be different from someone who smokes two packages/day.
80. Are you exposed to secondhand smoke at home or at work? Yes No
Secondhand smoke can have serious effects on both the mother and the fetus. To help the client identify such exposure and develop a plan to avoid such exposure, see STT Guidelines: Health Education–Secondhand Tobacco Smoke.
81. Are you using chewing tobacco? Yes No
The woman who uses chewing tobacco avoids possible lung problems, she and her fetus are still exposed to the harmful effects of nicotine. Some of the suggestions in STT Guidelines: Health Education–Tobacco Use, may also be helpful for this client.

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
The education and support you provide a client around tobacco use varies in relation to desire to quit. For suggestions for each of the above situations, see STT Guidelines: Health Education–Tobacco Use.
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
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
Questions 82–85 provide information on the client’s previous and past use of drugs and alcohol. To assist the client in deciding to quit and support her through that process, see STT Guidelines: Health Education–Drug and Alcohol Use.
87. If your partner uses drugs or alcohol, does this create problems for you? Yes No
The client may not use drugs or alcohol but her partner may and this can cause significant problems for her: stress, domestic violence, misuse of family income, etc. See pertinent sections of STT Guidelines for additional suggestions.

EDUCATION AND LANGUAGE

88. Years of education completed: 0–8 years 9–11 years 12–16 years 16+ years
Determining the client’s level of education may give the assessor some idea as to the client’s reading and comprehension levels, although this will probably require additional evaluation.
- 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
These questions are particularly important for teen clients, who should be encouraged to participate in school pregnant minor programs. Older clients who have not completed high school or equivalence may want to consider attending night school or other independent learning centers particularly if they are interested in achieving changes in their lives.
89. What language do you prefer to speak: English Other _____
90. What language do you prefer to read: English Other _____
To achieve maximum benefit from interventions and education, services must be presented in a spoken or written language that is understandable to the client. For additional suggestions, see STT Guidelines: First Steps–No Language in Common with Staff, Low Literacy Skills (for those patients with low or no reading ability in any language).
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
The client’s ability to read is separate from her interest in reading. Providing written materials to someone who does not read or who does not like to read is inappropriate. Written materials at a high reading level may also be inappropriate.

