FLORIDA DEPARTMENT OF HEALTH

Healthy Start
Prenatal/Woman Initial Assessment

Family/Home

Ask the participant what she feels are the family's *assets, strengths, and resources*. Ex: "What is working well for your family now? What are some of the positive things in your family's life?" Note below.
Family Assets, Strengths, and Resources

_____
_____
_____
_____
_____

Ask the participant what are the family's main concerns now that the participant is pregnant/postpartum. "Is there anything that is a worry to you right now?" Note below.
Family Concerns

_____
_____
_____
_____
_____

Through your discussion with the participant, please determine the nutritional practices of the participant. In addition, ask the participant what prescribed medications or over the counter medications the participant is currently taking. Please Note below:

Nutritional Assessment, Medications and Supplements

	Not Addressed	Yes	No	
Receiving WIC (circle one if applicable)	☐	☐	☐	**pending/not qualified**
Special Diet	☐	☐	☐	
Hyperemesis (morning sickness)	☐	☐	☐	
Food allergies	☐	☐	☐	
Meals per day (circle one if applicable)	☐	**1 2 3 4 or more**		
Type of Fluids (circle all that apply) **Amount _____**	☐	**milk /water/juice/soda/diet drinks/coffee/tea/alcohol**		
Raw/undercooked meats/seafood consumed **Amount _____**	☐	☐	☐	
PICA (clay, starch, paper, other)	☐	☐	☐	

Name:
ID No:
Date of Birth:

FLORIDA DEPARTMENT OF HEALTH

Vitamins/Supplements/Medications ☐ Folic Acid/Herbal/Iron/Medications/None/Prenatal Vitamins/Supplements/Others

Through interview, if face to face visit is in the community, or observation, if face to face visit is in the participant's home, assess the presence of the following items, household or conditions in the participant's home. Please note below.

Household Assessment

Exterior household status: adequately maintained ____ needs maintenance _____
Interior household status (clean, dirty, cluttered, smoky, crowded, hectic, safe, unsafe, unsanitary, malodorous)
Excluding participant, number of adult household members _____
Excluding participant, number of child (under age 18) household members _____
Excluding the participant, number of non-family household members _____
Current living situation (owns, rents, lives with boyfriend/family/friends, halfway home, homeless, other) _____
Type of residence (house, apartment, townhouse, government funded, mobile home, other) _____
Number of bedrooms _____

☐ Toilet facilities
☐ Safe infant sleeping arrangement
☐ Pets (cats, dogs, reptiles, rabbits, birds, livestock, other)
☐ Vermin
☐ Lead hazards
☐ Unsafe conditions (of house, in household)
☐ Other

Non-functioning items in the household

☐ Phone
☐ Smoke Detector
☐ Running Water
☐ Air Conditioner/Fan
☐ Heat
☐ Refrigerator
☐ Stove

Ask the participant about any interactions with a day care setting, cleaning used cat litter boxes, mold in the household or workplace, any exposure to second hand smoke, or any other environmental item that could cause a potential illness or risk to the participant. Please note below.

Current Exposures

☐ Child Care/Day Care exposure
☐ Cat litter
☐ Mold
☐ Second hand smoke
☐ Other

Through your discussion with the participant please review occupational/lifestyle. Please note below.

Participant's occupation/lifestyle

☐ Attending School

Name:
ID No:
Date of Birth:

FLORIDA DEPARTMENT OF HEALTH

☐Level of education completed (less than high school, high school, vocational, community college, university)
☐Employed yes_____ no_____ stay at home mom_____ unable to work due to disability _____
-Type of employment (radio button-Full time, part time, both)
-Length of employment
-Type of work
☐Job stress low_____ medium _____ high _____ none _____

Physical and Psychosocial Assessment

Using your observation and interviewing skills, check below your assessment of the participant.
Physical and Psychosocial Assessment
☐Friendly (talkative, easily engaged in conversation)
☐Quiet (withdrawn, not talkative, reserved)
☐Alert/awake
☐Drowsy
☐Cooperative
☐Uncooperative
☐Limited coping skills (overwhelmed by problems)
☐Confusion, displays lack of understanding
☐Appropriately dressed, clean
☐Unkempt, dirty
☐Restless/agitated
☐Shaking/tremors
☐Unable to focus, difficulty concentrating, scattered thoughts
☐Tearful, sad
☐Irritable, angry, tense
☐Anxious, fearful
☐Swelling
☐Cuts and bruises
☐Self reported history of mental health diagnosis
☐Disability
☐Other

Risks/Needs/Referrals

Please check below any risk factors identified through the initial assessment process. These risk factors would be in addition to those previously determined through the initial contact process.

New risk factors identified since initial contact? Yes _____ No _____

Risk Factors
☐ Abused as a child
☐Anxiety
☐ Domestic Violence
☐Lack of car seat

Name:
ID No:
Date of Birth:

FLORIDA DEPARTMENT OF HEALTH

- ☐ Medical condition
- ☐ Negative feelings about pregnancy or child
- ☐ Nutritional concern
- ☐ Sadness
- ☐ Second-hand smoke
- ☐ Transportation barriers
- ☐ Unsafe sleep environment for infant
- ☐ Other
- ☐ Above checked risk factors discussed with participant

Needs Identified and Referrals

Through your discussion with the participant please determine any current needs of the participant. Check below, along with indicating any referrals provided.

New needs identified since initial contact? Yes _____ No _____

Needs Identified	Referrals Provided	Education Provided
☐ Food	_____	_____
☐ Psychosocial/Mental health services	_____	_____
☐ Parenting education	_____	_____
☐ Childbirth education	_____	_____
☐ Nutrition education	_____	_____
☐ Shelter	_____	_____
☐ Clothing	_____	_____
☐ General Supplies	_____	_____
☐ School	_____	_____
☐ Employment	_____	_____
☐ Financial assistance	_____	_____
☐ Transportation	_____	_____
☐ Access to services	_____	_____
☐ Healthcare coverage	_____	_____
☐ Medical	_____	_____
☐ Dental	_____	_____
☐ Day Care	_____	_____
☐ Baby supplies	_____	_____
☐ Social support	_____	_____
☐ Access to Family Planning	_____	_____
☐ Smoking cessation	_____	_____
☐ Substance abuse treatment	_____	_____
☐ Domestic Violence Information	_____	_____
☐ Other	_____	_____

Evaluation/Summary

(Health education components below will be on a drop down in HMS for selection)
Health Education Provided

Name:
ID No:
Date of Birth:

FLORIDA DEPARTMENT OF HEALTH

- ☐ Baby Spacing/Family Planning
- ☐ Breastfeeding
- ☐ Childbirth
- ☐ Disaster/Safety Planning
- ☐ Immunizations
- ☐ Kick Count
- ☐ Medicaid Family Planning Waiver
- ☐ Nutrition
- ☐ Parenting
- ☐ Pre Term Labor Danger Signs
- ☐ Safe Sleep Environment
- ☐ Secondhand Smoke
- ☐ Shaken Baby Prevention
- ☐ SIDS Risk Reduction
- ☐ Other (text box)

Care Coordinator Evaluation

Method of Initial Assessment: Home Visit _____ Other Face-to-Face Encounter _____
Client level today _____
Plan of care evaluated today? _____
Plan of care changed today? (text box)_____
Follow-up with provider completed on (date) ____ by _____
Follow-up with provider completed by (method)? Letter _____ Phone_____

Overall Assessment Summary:

Signature:_____ **Date:_____**

Authenticate:_____ **Date:_____**

Name:
ID No:
Date of Birth: