Name of Participant:

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Phone:

Early Head Start Parents: Please complete by mother of child if pregnant

|  |  |  |
| --- | --- | --- |
| Are you Pregnant? □ Yes □ NoIf you answered yes, please answer the following questions.Due date/Expected Delivery Date: | Is your pregnancy covered by Medical Insurance?□ Public Assistance□ Private Insurance □ NoneProviders Name: | Prenatal care received? □ Yes □ No |
| Visited regularly by nurse, social worker, school support person, etc. during current pregnancy:Visited by: Agency:  | Participating in support or educational groups for pregnancy, child birth, or parenting during pregnancy?  □ Yes □ No | Primary prenatal care provider:Primary Health Care Provider: (if different) |
| Substance abuse use during pregnancy (mark all that apply):Alcohol □ Yes □ No Other drugs □ Yes □ No specify: Caffeine □ Yes □ No NON-prescription drugs □ Yes □ No specify: Cigarettes □ Yes □ No Prescription drugs □ Yes □ No specify:  |
| Medical or Health services currently received: □ NO SERVICES CURRENTLY BEING RECEIVED□ Medical assistance since \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ Substance abuse treatment since \_\_\_\_/\_\_\_\_/\_\_\_\_Other services specify: □ Mental Health counseling/treatment since \_\_\_\_/\_\_\_\_/\_\_\_\_□ WIC/other nutritional services since \_\_\_\_/\_\_\_\_/\_\_\_\_ if served on WIC please provide hemoglobin or hematocrit information to the FACS. |

Completed at postpartum:

Pregnancy/birth history (please explain any “yes” answers on the line provided after each question)

□ Yes □ No Did mother have any health problems during this pregnancy or during delivery?

□ Yes □ No Did mother visit physician fewer than two times during pregnancy?

□ Yes □ No Was child born outside of hospital?

□ Yes □ No What was child’s birth weight? lbs. oz.

□ Yes □ No Were there any health concerns with child at birth?

□ Yes □ No Did child or mother stay in hospital for medical reasons longer than usual?

□ Yes □ No Is mother pregnant now?

□ Yes □ No Do you have any questions about the child’s language or speech?

□ Yes □ No Do you have any questions about the child’s overall health and development?

□ Yes □ No Is the child excepted to be experiencing a developmental delay?

□ Yes □ No Is child on an IFSP (Individual Family Service Plan) or IEP (Individual Education Plan)

 If yes: Where: Date of beginning services:

□ Yes □ No Has the child received any services to address special needs/disabilities?

 Types of services received: Provider:

 Address: Phone:

Prenatal:

Date of last physical exam, Pregnant: \_\_\_/\_\_\_/\_\_\_ Name of Physician:

Date of last dental exam, Pregnant: \_\_\_/\_\_\_/\_\_\_ Name of Dentist:

Postpartum:

Date of last physical exam, Infant/Toddler: \_\_\_/\_\_\_/\_\_\_ Name of Physician:

Date of last dental exam, Infant/Toddler: \_\_\_/\_\_\_/\_\_\_ Name of Dentist: