Combined Initial Perinatal Assessment
Psychosocial

Patient Identifier

1. **Pregnancy Information**
   DOB ______________ Age _________________
   If teen, years since menarche _________________ ❑ N/A
   EDC ______________ Wks. Gestation ________
   Approximate conception date _________________
   Grav ______________ Para _________________
   TAB ______________ SAB _________________
   Date last pregnancy ended ____________________ ❑ N/A

2. Problems with previous pregnancies? ❑ No
   ❑ Yes, describe:

3. Current medical problems? ❑ No
   ❑ Yes, describe:

4. Planned pregnancy? ❑ Yes
   ❑ No, describe:

5. Wanted pregnancy? ❑ Yes
   ❑ No, describe:

   Considering abortion/adoption? ❑ No
   ❑ Yes, describe:

6. Previous pregnancy loss/infant death? ❑ No
   ❑ Yes, describe:

7. FOB/partner accepts pregnancy? ❑ Yes
   ❑ No, describe:

Family/Support System

8. Members of household (not including patient)
   number of adults: ______
   relationship to patient:

   number of children: ______
   relationship to patient:

9. Patient's children all live with her? ❑ N/A ❑ Yes
   ❑ No, describe:

10. Patient turns to for emotional support:
    ❑ FOB/partner ❑ family member: _________________
    ❑ friend: _______________ ❑ other: ___________________
    ❑ no one, describe:

11. Current family problems/stressors? ❑ No
    ❑ Yes, describe:

12. Current contact with any social service agencies? ❑ No
    ❑ Yes, describe:

Emotional Concerns

13. Ever seen a counselor for emotional problems? ❑ No
    ❑ Yes, describe:

14. Ever been prescribed drugs for emotional problems? ❑ No
    ❑ Yes, describe:

15. Ever been hospitalized for psychiatric problems? ❑ No
    ❑ Yes, describe:

Domestic Violence

16. Ever emotionally, physically, or sexually abused by a partner or someone close to you? ❑ No
    ❑ Yes, describe:

17. Within the last year ever been hit, slapped, kicked, pushed, shoved, forced to have sex or otherwise physically hurt by partner or ex-partner? ❑ No
    ❑ Yes, describe:

18. Afraid of partner or ex-partner? ❑ No
    ❑ Yes, describe:

19. Patient's children ever been victims of violence or witnessed violence in the home or community? ❑ N/A ❑ No
    ❑ Yes, describe:

20. Guns or other weapons in the home? ❑ No
    ❑ Yes, describe:

Employment/Finances

21. Source of financial support:
    ❑ self, type of work: ______________________________
    ❑ FOB/partner, type of work: ______________________
    ❑ family member:__________ ❑ friend:____________
    ❑ CalWORKS ❑ GA ❑ other: _________________
    ❑ problems:

Housing

22. Type of housing:
    ❑ apartment ❑ hotel/motel ❑ house ❑ other:
    ❑ problems:

23. **Goals for this pregnancy**: ❑ healthy baby ❑ other:

Combined Initial Perinatal Assessment

Health Education

Patient Identifier

❑ **Orientation completed, per protocol: Minutes______**

24. English language:

	Poor	Fair	Good
speaking	❑	❑	❑
writing/reading ❑ non-reader	❑	❑	❑

25. Other language: ________________________ ❑ N/A

	Poor	Fair	Good
speaking	❑	❑	❑
writing/reading ❑ non-reader	❑	❑	❑

26. Likes to learn by:
❑ reading/handouts ❑ classes/groups
❑ individual teaching ❑ videos
❑ other:

27. Last grade completed:________ ❑ 12th or over

28. Any mental, emotional, or physical (hearing, vision, or learning) disabilities that affect ability to learn? ❑ No
❑ Yes, describe:

29. Birthplace:_________________ ❑ US born
❑ If not US born, length of time living in US: ________months/years

30. Ever used health care services in U.S.? ❑ Yes
❑ No, comments:

31. Dental check-up within past 12 months? ❑ Yes
❑ No, comments:

32. Transportation to clinic: ❑ bus ❑ car ❑ walk
❑ taxi ❑ other:
❑ problems:

33. Always use a seatbelt? ❑ Yes
❑ No, explain:

34. Previous knowledge/experience with:

pregnancy	❑ No	❑ Yes
prenatal care	❑ No	❑ Yes
delivery/postpartum self-care	❑ No	❑ Yes
infant care and safety	❑ No	❑ Yes

35. Person to support/participate in health education? ❑ Yes
❑ No, comments:

36. Who gives advice about being pregnant?
❑ mother ❑ mother-in-law ❑ female friend _______
❑ partner ❑ grandmother ❑ other _____________

37. What are the most important things they have advised?

38. Use any home remedies? ❑ No
❑ Yes, which ones/what purpose:

39. Exposed to chemicals or other dangers at work or home (chemicals, paints, polishes, pesticides, lead, cats, raw food, raw fish, hot baths, douching, x-rays)? ❑ No
❑ Yes, describe:

40. Offered HIV test, provided information per protocol? ❑ Yes
❑ No, comments:

41. Did either of your parents have any problem with drugs or alcohol? ❑ No
❑ Yes, describe:

42. Does your partner have any problem with drugs or alcohol? ❑ No
❑ Yes, describe:

43. Have you ever drunk beer/wine/liquor? ❑ No
❑ Yes

44. In the month before you knew you were pregnant, how much beer/wine/liquor did you drink? ❑ None
Type(s):
❑ was drinking _________ per day/week/month
❑ currently drinking ______per day/ week/month

45. In the month before you knew you were pregnant, how many cigarettes did you smoke? ❑ None
❑ was smoking _________ per day/week
❑ currently smoking ______per day/week

46. Exposed to 2nd hand smoke at home/elsewhere? ❑ No
❑ Yes, describe:

47. In the month before you knew you were pregnant, used "street"drugs? ❑ None
Type(s):
❑ was using _________ per day/week/month
❑ currently using ______per day/week/month

Combined Initial Perinatal Assessment

Nutrition

Patient Identifier

48. Food recall/frequency completed ❑ Yes

49. Number of times per day usually eats?

    1 2 3 4 5 6 7 more often

50. Daily liquid intake (# of cups/glasses/cans):
    water____ juice ____ milk ____
    decaffeinated coffee/tea ____
    regular coffee/ tea_____
    regular soda /punch _____ decaf soda _____

    Total # of cups/glasses/cans: ______
    Of these, # that are caffeinated ______

51. Allergic to foods? ❑ No
    ❑ Yes, describe:

52. Any foods or food groups avoided? ❑ No
    (such as dairy, meat, etc.)
    ❑ Yes, list which foods and note reason:

53. Food or non-food cravings? ❑ No
    (examples of non-foods are ice, plaster, cornstarch, dirt, clay, laundry starch)
    ❑ Yes, describe:

54. Current discomforts? ❑ No
    ❑ nausea ❑ vomiting ❑ constipation
    ❑ edema ❑ diarrhea ❑ heartburn
    ❑ Other, describe:

55. Nutrition-related medical conditions? ❑ No
    (such as chronic illness)
    ❑ Yes, describe:

56. Clinical observations of poor nutritional status? ❑ No
    ❑ Yes, describe:
    (such as poor teeth or mouth sores)

57. Knowledge or experience with breastfeeding?
    ❑ took class ❑ observed friends/family

    ❑ personal experience? Circle and comment:
    negative none positive

58. Plan to breastfeed?
    ❑ No ❑ combine with formula ❑ not sure ❑ Yes

59. Currently taking prenatal vitamins? ❑Yes
    ❑ No, comments:
    ❑ No, needs prescription:

60. Currently taking (if yes; type, amount, frequency): ❑ None
    ❑ vitamins, minerals (in addition to prenatal vitamins):
    - ❑ folic acid
    - ❑ iron
    - ❑ calcium
    - ❑ other:

    ❑ natural remedies, herbal teas:

    ❑ laxatives, antacids:

    ❑ over-the-counter medicine (cough syrup, aspirin, etc.):

    ❑ prescription medications:

    ❑ other:

61. Ever run out of food? ❑ No
    ❑ Yes, describe:

62. Receiving any financial/other help to get food? ❑ No
    ❑ WIC, site: ____________________
    ❑ food stamps ❑ emergency food
    ❑ SHARE ❑ other:

63. Have access to a working kitchen? ❑ Yes
    ❑ No. Way to cook food? Comment:

    ❑ No. Refrigerator to store food? Comment:

64. Exercising at least 3 times each week?
    ❑ Yes, comment:

    ❑ No, comment:

65. Plot weight on appropriate grid.
    Weight pre-pregnancy: ______ lb. Height _____

    Based on above, recommended weight gain is:
    ❑ 28-40 lb. (Underweight) (trimester 2/3 wt. gain 4+/mo)
    ❑ 25-35 lb. (Normal) (trimester 2/3 wt. gain 4+/mo)
    ❑ 15-25 lb. (Overweight) (trimester 2/3 wt. gain 2/mo)
    ❑ 15 or more lb. (Obese) (varies)

    Today's weight _________ lb.
    Weight gain to date this pregnancy________ lb.

66. Current weight gain appropriate? ❑ Yes
    ❑ No, excessive weight gain
    ❑ No, inadequate weight gain