

CLIENT INFORMATION TAB

Client is a Caregiver/Adult:

Client Name _____ Date of Activity: _____
(MM/DD/YYYY)

Client Address: _____ City: _____ Zip Code: _____

County of Residence: _____ Phone Number: _____

E-mail: _____

Primary Healthcare Coverage:

- ☐ None/Self Pay
- ☐ Private Insurance
- ☐ Tricare
- ☐ KanCare/Medicaid
- ☐ CHIP
- ☐ Medicare
- ☐ Unknown/Not Reported

Secondary Healthcare Coverage:

- ☐ None/Self Pay
- ☐ Private Insurance
- ☐ Tricare
- ☐ KanCare/Medicaid
- ☐ CHIP
- ☐ Medicare
- ☐ Unknown/Not Reported

Household Size: _____ Annual Household Income: \$ _____

Has the client had a well visit during the last 12 months? (With any provider, not just within the program)

- ☐ No
- ☐ Yes

Do you have a Medical Home?

- ☐ No
- ☐ Yes

Go to Visit Information Tab

CLIENT IS A CHILD:

Client Name) _____ Date of Activity: _____
(MM/DD/YYYY)

Client Address: _____ City: _____ Zip Code: _____

County of Residence: _____ Phone Number: _____

E-mail: _____

Primary Healthcare Coverage:

- ☐ None/Self Pay
- ☐ Private Insurance
- ☐ Tricare
- ☐ KanCare/Medicaid
- ☐ CHIP
- ☐ Medicare
- ☐ Unknown/Not Reported

Secondary Healthcare Coverage:

- ☐ None/Self Pay
- ☐ Private Insurance
- ☐ Tricare
- ☐ KanCare/Medicaid
- ☐ CHIP
- ☐ Medicare
- ☐ Unknown/Not Reported

Household Size: _____ **Annual Household Income: \$** _____

Has the client had a well visit during the last 12 months? (With any provider, not just within the program)

- ☐ No
- ☐ Yes

Do you have a Medical Home?

- ☐ No
- ☐ Yes

Does the client have a special health care need or disability? (Has a medical diagnosis or requires care beyond general preventive care)

- ☐ No
- ☐ Yes - **Is the child needing a medical diagnosis?**
 - ☐ Yes
 - ☐ No - **Was the child diagnosed through Newborn Screening?**
 - ☐ Yes
 - ☐ No **Does the child have any of the following conditions:** (select all)
 - ☐ Craniofacial
 - ☐ Neurological
 - ☐ Seizures
 - ☐ Hydrocephalus or Microcephaly
 - ☐ Orthopedic Needs
 - ☐ Spinal Bifida
 - ☐ Hearing Loss
 - ☐ Juvenile Rheumatoid Arthritis
 - ☐ Cardiac Condition
 - ☐ Hemophilia
 - ☐ Glaucoma
 - ☐ Congenital Cataract, or Retinal Disorder
 - ☐ Gastrointestinal or Genitourinary Diagnosis
 - ☐ Other -**Specify Other SHCN Condition(s):**

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VISIT INFORMATION TAB

CHILD ONLY:

Program:

- ☐ Maternal Child Health (MCH)

Does anyone in the household smoke or use vaping devices containing tobacco, nicotine, or other substances?

- ☐ No
- ☐ Yes

Over the past 2 weeks, how often have you been bothered by the following problems?

Little interest in doing things

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Feeling down, depressed, or hopeless

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Feeling nervous, anxious, or on edge

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Not being able to stop worrying

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Do you have someone to turn to for day-to-day support?

- ☐ No
- ☐ Yes

Go to Maternal Child Health Tab

CAREGIVER/ADULT ONLY:

Program:

- ☐ Maternal Child Health (MCH)

Would you (and/or your partner) like to become pregnant in the next year?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Okay either way
- ☐ Currently Pregnant

Do you have a child or children?

- ☐ No
- ☐ Yes - Do you have someone to turn to for day-to-day support with parenting or raising children?
 - ☐ No
 - ☐ Yes

Are you pregnant?

- ☐ No - Not pregnant - In the past year, how often have you used:

Alcohol? (For men, 5 or more drinks a day. For women, 4 or more drinks a day)

- ☐ Never
- ☐ Once or Twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or Almost Daily

Tobacco, Nicotine, and/or Vaping Products?

- ☐ Never
- ☐ Once or Twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or Almost Daily

Prescription Drugs for Non-Medical Reasons?

- ☐ Never
- ☐ Once or Twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or Almost Daily

Illegal Drugs? (Including marijuana)

- ☐ Never
- ☐ Once or Twice
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or Almost Daily

Does anyone in the household smoke or use vaping devices containing tobacco, nicotine, or other substances?

- ☐ No
- ☐ Yes

- Yes, Pregnant - **How often have you used the following substances since you found out that you are pregnant:**

Alcohol (since learning of pregnancy)?

- I am using alcohol more
- My alcohol use is about the same
- I have reduced the amount or frequency of alcohol use
- I have stopped using alcohol
- I have never used alcohol

Tobacco, Nicotine, and/or Vaping Products (since learning of pregnancy)?

- I am using tobacco, nicotine, and/or vaping more
- My tobacco, nicotine, and/or vaping use is about the same
- I have reduced the amount or frequency of tobacco, nicotine, and/or vaping use
- I have stopped using tobacco, nicotine, and/or vaping products
- I have never used tobacco, nicotine, and/or vaping products

Prescription Drugs for Non-Medical Reasons (since learning of pregnancy)?

- I am using prescription drugs more
- My prescription drug use is about the same
- I have reduced the amount or frequency of prescription drug use
- I have stopped using prescription drugs
- I have never used prescription drugs

Illegal Drugs (since learning of pregnancy)?

- I am using illegal drugs more
- My illegal drug use is about the same
- I have reduced the amount or frequency of illegal drug use
- I have stopped using illegal drugs
- I have never used illegal drugs

Does anyone in the household smoke or use vaping devices containing tobacco, nicotine, or other substances?

- No
- Yes

Over the past 2 weeks, how often have you been bothered by the following problems?

Little interest in doing things

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling down, depressed, or hopeless

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling nervous, anxious, or on edge

- Not at all
- Several days
- More than half the days
- Nearly every day

Not being able to stop worrying

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Do you have someone to turn to for day-to-day support?

- ☐ No
- ☐ Yes

Go to Maternal Child Health Tab

MATERNAL CHILD HEALTH TAB

IF YOU ARE PREGNANT:

What is your Due Date: _____

During this pregnancy, have you been screened for:

(select all that apply)

- ☐ Depression
- ☐ Anxiety
- ☐ Substance Use
- ☐ Not Screened

Program Services Provided? (select all that apply)

- ☐ Ages and Stages Questionnaire
- ☐ Breastfeeding
- ☐ Care Coordination
- ☐ Case Management
- ☐ Maternal Depression
- ☐ Medical Home
- ☐ Postpartum Care
- ☐ Prenatal Care
- ☐ Safe Sleep
- ☐ Transition
- ☐ Well Visit

Education Provided? (select all that apply)

- ☐ Adolescent Care
- ☐ Behavioral/Mental Health
- ☐ Breastfeeding
- ☐ Developmental Milestones
- ☐ Early Learning
- ☐ Maternal Warning Signs
- ☐ Medical Home
- ☐ Parenting Support
- ☐ Postpartum Care
- ☐ Prenatal Care
- ☐ Safe Sleep
- ☐ Substance Use
- ☐ Transition
- ☐ Well Visit

[Go to End of Visit Tab](#)

IF YOU ARE NOT PREGNANT:

Have you given birth in the past year?

- ☐ No
- ☐ Yes - Infant's Date of Birth: _____

Did you initiate breastfeeding at birth?

- ☐ No
- ☐ Yes - **How long did you exclusively breastfeed?**
 - ☐ < 1 month
 - ☐ 1 month
 - ☐ 2 months
 - ☐ 3 months
 - ☐ 4 months
 - ☐ 5 months
 - ☐ 6 months
 - ☐ 7 months
 - ☐ 8 months
 - ☐ 9 months
 - ☐ 10 months
 - ☐ 11 months
 - ☐ 12 months
 - ☐ > 12 months

Have you attended your postpartum visit

- ☐ No
- ☐ Yes - **Date of postpartum visit:** _____
- ☐ Scheduled - **Date of postpartum visit:** _____

During and/or after the pregnancy, were you screened for the following? (select all that apply)

- ☐ Depression
- ☐ Anxiety
- ☐ Substance Use
- ☐ Not Screened

Program Services Provided? (select all that apply)

- ☐ Ages and Stages Questionnaire
- ☐ Breastfeeding
- ☐ Care Coordination
- ☐ Case Management
- ☐ Maternal Depression
- ☐ Medical Home
- ☐ Postpartum Care
- ☐ Prenatal Care
- ☐ Safe Sleep
- ☐ Transition
- ☐ Well Visit

Education Provided? (select all that apply)

- ☐ Adolescent Care
- ☐ Behavioral/Mental Health
- ☐ Breastfeeding
- ☐ Developmental Milestones
- ☐ Early Learning
- ☐ Maternal Warning Signs
- ☐ Medical Home

Maternal Child Health Encounter Form

-
- Parenting Support
 - Postpartum Care
 - Prenatal Care
 - Safe Sleep
 - Substance Use
 - Transition
 - Well Visit

Comments/Notes:

Go to End of Visit Tab

CHILD INFORMATION

Has the parent completed a child developmental screening tool for a child ages 9 months through 35 months, within the past year?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Over 4 years old

Program Services Provided: (select all that apply)

- ☐ Ages and Stages Questionnaire (ASQ)
- ☐ Breastfeeding
- ☐ Care Coordination
- ☐ Case Management
- ☐ Maternal Depression
- ☐ Medical Home
- ☐ Postpartum Care
- ☐ Prenatal Care
- ☐ Safe Sleep
- ☐ Transition
- ☐ Well Visit

Education Provided: (select all that apply)

- ☐ Adolescent Care
- ☐ Behavioral/Mental Health
- ☐ Breastfeeding
- ☐ Developmental Milestones
- ☐ Early Learning
- ☐ Maternal Warning Signs
- ☐ Medical Home
- ☐ Parenting Support
- ☐ Postpartum Care
- ☐ Prenatal Care
- ☐ Safe Sleep
- ☐ Substance Use
- ☐ Transition
- ☐ Well Visit

Comments/Notes:

END OF VISIT TAB

Were any referrals made for this visit: (select all that apply)

- ☐ No Referrals
- ☐ Behavior Health
- ☐ Breastfeeding
- ☐ Developmental Screening
- ☐ Depression
- ☐ Infant Care
- ☐ Medical Home
- ☐ Prenatal Care
- ☐ Postpartum Care
- ☐ Substance Use
- ☐ Transition
- ☐ Well Visit

Were any health risk screening tools administered at this visit: (select all that apply)

- ☐ No Screening Tools
- ☐ ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test)
- ☐ CRAFFT-N (Substance use screening for adolescents)
- ☐ EPDS (Edinburgh Postnatal Depression Scale)
- ☐ GAD-7 (Generalized Anxiety Disorder screening)
- ☐ PHQ-A Patient Health Questionnaire for Adolescents (depression)
- ☐ PHQ-9 Patient Health Questionnaire (depression)
- ☐ SDOH (Social Determinants of Health assessment)
- ☐ Other – **Specify other screening tool:** _____

Please complete the indicated risk screening tools.