Maternal Child Health Encounter Form

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: _____

Maternal Child Health Encounter Form

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):**

_____

Go to Visit Information Tab

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
- Morer than half the days
- Nearly every day

Feeling down, depressed, or hopeless
- Not at all
- Several days
- Morer than half the days
- Nearly every day

Feeling nervous, anxious, or on edge
- Not at all
- Several days
- Morer than half the days
- Nearly every day

Not being able to stop worrying
- Not at all
- Several days
- Morer 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 Encounter Form

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
- Morer than half the days
- Nearly every day

Feeling down, depressed, or hopeless
- Not at all
- Several days
- Morer than half the days
- Nearly every day

Feeling nervous, anxious, or on edge
- Not at all
- Several days
- Morer than half the days
- Nearly every day

Not being able to stop worrying

- Not at all
- Several days
- Morer 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

Maternal Child Health Encounter Form

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

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

Comments/Notes:

Go to End of Visit Tab

Maternal Child Health Encounter Form

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.