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**CLIENT INFORMATION TAB**

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**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](#)**

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## VISIT INFORMATION TAB

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### CAREGIVER/ADULT ONLY:

**Program:**

- ☐ Pregnancy Maintenance Initiative (PMI)

**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 PMI Tab***

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**PMI TAB**

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***Client is Pregnant (Prenatal Visit)***

**New Enrollee? (Select one)**

- ☐ Yes
- ☐ No

**What is your Due Date:** \_\_\_\_\_

**Initiated Prenatal Care (PNC): (Select one)**

- ☐ 1st Trimester
- ☐ 2nd Trimester
- ☐ 3rd Trimester
- ☐ No PNC initiated

**Complied with recommended PNC appointments after initiating care? (Select one)**

- ☐ Yes
- ☐ No

**During this pregnancy, were you screened for (select all that apply)**

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

**Education Provided (Complete only if education was provided):**

- ☐ Adoption Counseling/Services
- ☐ Alcohol/Drugs Abuse
- ☐ Behavioral Health (Other than Perinatal Mood and Anxiety Disorders)
- ☐ Breastfeeding
- ☐ Child Care Resources
- ☐ Child Development/Developmental Screening
- ☐ Car seat safety/installation
- ☐ Continuation of Education
- ☐ Count the Kicks
- ☐ Family Violence
- ☐ Father Involvement
- ☐ Food Assistance
- ☐ Health Care Coverage/Medicaid Eligibility
- ☐ Health Care System Navigation
- ☐ Health Care Transition
- ☐ Immunizations
- ☐ Infant Care
- ☐ Injury prevention/safety
- ☐ Labor/Childbirth
- ☐ Lead Prevention
- ☐ Lifestyle risk factors/prenatal exposures
- ☐ Maternal Warning Signs
- ☐ Medical Home
- ☐ Nutrition
- ☐ Oral Health
- ☐ Parenting
- ☐ Perinatal Health
- ☐ Perinatal Mood and Anxiety Disorders
- ☐ Postpartum care

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- ☐ Preconception/Interconception
  - ☐ Prenatal Care
  - ☐ Preterm Labor
  - ☐ Reproductive Health/Family Planning
  - ☐ Safe Sleep
  - ☐ Smoking Cessation/Second-hand exposure
  - ☐ Special Healthcare Needs
  - ☐ State/local resources
  - ☐ Suicide Prevention
  - ☐ Transportation Assistance
  - ☐ Utilities Assistance
  - ☐ Weight Management
  - ☐ Well Adolescent
  - ☐ Well Child
  - ☐ Well Woman
  - ☐ WIC
  - ☐ Other **Specify other education provided:** \_\_\_\_\_

**Client left the program for the following reasons: (Select one)**

- ☐ N/A-still participating
- ☐ Completed Goals
- ☐ Client Terminated Participation
- ☐ Miscarriage
- ☐ Infant age 6 months
- ☐ Client left service area
- ☐ Client cannot be located
- ☐ Other **Specify other reason:** \_\_\_\_\_

**Exit Date:** \_\_\_\_\_

**Notes:**

**Go to End of Visit Tab**

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**PMI TAB**

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**Client is NOT Pregnant (Postnatal Visit)**

**New Enrollee? (Select one)**

- ☐ Yes
- ☐ No

**Date of infant's birth:** \_\_\_\_\_

**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

**Current Infant Feeding Method:**

- ☐ Formula
- ☐ Breastmilk (breastfeeding/pumping)
- ☐ Both

**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

**Gestational age of infant at birth (in weeks) (Select one)**

- ☐ <32 weeks
- ☐ 32-27 weeks
- ☐ >37 weeks

**What type of birth did you have:**

- ☐ Vaginal
- ☐ Cesarean
- ☐ Vaginal Birth After Cesarean (VBAC)

**Multiple Birth?(twins/triplets)**

- ☐ No
- ☐ Yes

**Infant received one-week visit to pediatrician/doctor? (Select one)**

- ☐ No
- ☐ Yes

**Infant placed for adoption? (Select one)**

- ☐ No
- ☐ Yes - **Date of adoptive placement:** \_\_\_\_\_

**Age of mother at time of adoptive placement:** \_\_\_\_\_

**Fetal/infant death? (Select one)**

- ☐ No
- ☐ Yes - **Date of death:** \_\_\_\_\_

**Age/Time of death? (Select one)**

- ☐ Miscarriage
- ☐ Fetal death/stillborn
- ☐ <7 days
- ☐ 7-27 days
- ☐ 28-364 days

**Education Provided (Complete only if education was provided):**

- ☐ Adoption Counseling/Services
- ☐ Alcohol/Drugs Abuse
- ☐ Behavioral Health (Other than Perinatal Mood and Anxiety Disorders)
- ☐ Breastfeeding
- ☐ Child Care Resources
- ☐ Child Development/Developmental Screening
- ☐ Car seat safety/installation
- ☐ Continuation of Education
- ☐ Count the Kicks
- ☐ Family Violence
- ☐ Father Involvement
- ☐ Food Assistance
- ☐ Health Care Coverage/Medicaid Eligibility
- ☐ Health Care System Navigation
- ☐ Health Care Transition
- ☐ Immunizations
- ☐ Infant Care
- ☐ Injury prevention/safety
- ☐ Labor/Childbirth
- ☐ Lead Prevention
- ☐ Lifestyle risk factors/prenatal exposures
- ☐ Maternal Warning Signs
- ☐ Medical Home
- ☐ Nutrition
- ☐ Oral Health
- ☐ Parenting
- ☐ Perinatal Health
- ☐ Perinatal Mood and Anxiety Disorders
- ☐ Postpartum care
- ☐ Preconception/Interconception

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- ☐ Prenatal Care
  - ☐ Preterm Labor
  - ☐ Reproductive Health/Family Planning
  - ☐ Safe Sleep
  - ☐ Smoking Cessation/Second-hand exposure
  - ☐ Special Healthcare Needs
  - ☐ State/local resources
  - ☐ Suicide Prevention
  - ☐ Transportation Assistance
  - ☐ Utilities Assistance
  - ☐ Weight Management
  - ☐ Well Adolescent
  - ☐ Well Child
  - ☐ Well Woman
  - ☐ WIC
  - ☐ Other **Specify other education provided:** \_\_\_\_\_

**Client left the program for the following reasons: (Select one)**

- ☐ N/A-still participating
- ☐ Completed Goals
- ☐ Client Terminated Participation
- ☐ Miscarriage
- ☐ Infant age 6 months
- ☐ Client left service area
- ☐ Client cannot be located
- ☐ Other - **Specify other reason:** \_\_\_\_\_

**Exit Date:** \_\_\_\_\_

**Notes:**

**Go to End of Visit Tab**

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## END OF VISIT TAB

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**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.*