
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

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VISIT INFORMATION TAB

CAREGIVER/ADULT ONLY:

Program:

- ☐ Teen Pregnancy Targeted Case Management (TPTCM)

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

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TPTCM TAB

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):

- ☐ Prenatal/Perinatal/Postpartum
 - ☐ Prenatal Care
 - ☐ Perinatal Health
 - ☐ Postpartum Care
 - ☐ Preconception/Interconception
 - ☐ Preterm Labor
 - ☐ Count the Kicks
- ☐ Parenting/Childcare/Safety
 - ☐ Parenting
 - ☐ Father Involvement
 - ☐ Infant Care
 - ☐ Child Development/Developmental Screening
 - ☐ Child Care Resources
 - ☐ Safe Sleep
 - ☐ Car seat safety/installation
 - ☐ Injury prevention/safety
 - ☐ Lead Prevention
- ☐ Health/Lifestyle/Nutrition
 - ☐ Nutrition
 - ☐ Weight Management
 - ☐ Lifestyle risk factors/prenatal exposures
 - ☐ Smoking Cessation/Second-hand exposure
 - ☐ Breastfeeding
 - ☐ Oral Health

- Mental Health/Behavioral Health
 - Mental /Behavioral Health (Other than Perinatal Mood Disorders)
 - Perinatal Mood and Anxiety Disorders
 - Alcohol/Drugs Abuse
 - Suicide Prevention
- Healthcare Access/System Navigation
 - Health Care Coverage/Medicaid Eligibility
 - Health Care System Navigation
 - Health Care Transition
 - Medical Home
- Resources/Assistance
 - WIC
 - Food Assistance
 - Utilities Assistance
 - Transportation Assistance
 - State/local resources
 - Adoption Counseling/Services
 - Continuation of Education
- Preventive/Well-Care
 - Well Adolescent
 - Well Child
 - Well Woman
 - Immunizations
 - Special Health Care Needs
- Reproductive Health/Family Planning
- Other **Specify other education provided:** _____

During the program, client enrolled in: (Select one)

- High School
- GED Program
- Vocation/Technical Schhol
- Community College
- 4-year College or University
- None

Was there a second pregnancy after enrollment in program: (Select one)

- No
- Yes -**Date of pregnancy reported:** _____

Did the client complete basic education or vocational goals prior to 2nd pregnancy?

- No
- Yes

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

- Still participating in program
- Completed Goals
- Client Terminated Participation
- Miscarriage
- Infant age 12 months
- Client left/moved service area
- Client cannot be located
- Other - **Specify other reason:** _____

Exit Date: _____

Comments/Notes:

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TPTCM TAB

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:** _____

Were you screened for the following during the pregnancy? (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):

- ☐ Prenatal/Perinatal/Postpartum
 - ☐ Prenatal Care
 - ☐ Perinatal Health
 - ☐ Postpartum Care
 - ☐ Preconception/Interconception
 - ☐ Preterm Labor
 - ☐ Count the Kicks
- ☐ Parenting/Childcare/Safety
 - ☐ Parenting
 - ☐ Father Involvement
 - ☐ Infant Care
 - ☐ Child Development/Developmental Screening
 - ☐ Child Care Resources
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 - ☐ Weight Management
 - ☐ Lifestyle risk factors/prenatal exposures
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 - ☐ Breastfeeding
 - ☐ Oral Health
- ☐ Mental Health/Behavioral Health
 - ☐ Mental /Behavioral Health (Other than Perinatal Mood Disorders)
 - ☐ Perinatal Mood and Anxiety Disorders
 - ☐ Alcohol/Drugs Abuse
 - ☐ Suicide Prevention

- Healthcare Access/System Navigation
 - Health Care Coverage/Medicaid Eligibility
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 - Well Child
 - Well Woman
 - Immunizations
 - Special Health Care Needs
- Reproductive Health/Family Planning
- Other **Specify other education provided:** _____

Was there a second pregnancy after enrollment in program: (Select one)

- No
- Yes -**Date of pregnancy reported:** _____

Did the client complete basic education or vocational goals prior to 2nd pregnancy?

- No
- Yes

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

- Still participating in program
- Completed Goals
- Client Terminated Participation
- Miscarriage
- Infant age 12 months
- Client left/moved service area
- Client cannot be located
- Other - **Specify other reason:** _____

Exit Date: _____

Comments/Notes:

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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.