Help your baby have a healthy start in life!

Now that you've found out you are pregnant, you'll want to give your baby the healthiest start in life. No one wants their baby to be born too small, too early, or very sick. Let us help you find out if anything in your life could cause these problems. You may qualify for a variety of free services from the Healthy Start Program or the Healthy Families Program, no matter what your income level is! Please answer the following questions to find out if you have any risks that could affect your health or your baby's health.* Your answers to these questions are confidential. (Please complete in ink.)

	YES	NO
1. Have you graduated from high school or received a GED?	☐	☐ 1
2. Are you married now?	☐	☐ 1
3. Are there any children at home younger than 5 years old?	☐	☐
4. Are there any children at home with medical or special needs?	☐	☐
5. Is this a good time for you to be pregnant?	☐	☐
6. In the last month, have you felt down, depressed or hopeless?	☐ 1	☐
7. In the last month, have you felt alone when facing problems?	☐	☐
8. Have you ever received mental health services or counseling?	☐	☐
9. In the last year, has someone you know tried to hurt you or threaten you?	☐	☐
10. Do you have trouble paying your bills?	☐	☐

11. What race are you? Check one or more.
    ❑ White ❑ 3 Black ❑ Other _____
12. In the last month, how many alcoholic drinks did you have per week?
    _____ drinks 1 ❑ did not drink
13. In the last month, how many cigarettes did you smoke a day? *(a pack has 20 cigarettes)*
    _____ cigarettes 1 ❑ did not smoke
14. Thinking back to just before you got pregnant, did you want to be…….?
    ❑ 1 not pregnant ❑ pregnant now ❑ pregnant later
15. Is this your first pregnancy? *If yes, skip 15a and 15b:*
    ❑ 2 Yes ❑ No

    15a. Please mark any of the following that have happened.
    - ❑ 3 Stillbirth = baby not born alive
    - ❑ 3 Premature birth (born 3 weeks or more before due date)
    - ❑ 3 Low birth weight birth (less than 5 pounds, 8 ounces)
    - ❑ None of the above

    15b. What date did your LAST PREGNANCY end?
    _____ month _____ year

PATIENT INFORMATION

Name: First Last M.I.	Social Security Number:	Date of Birth (mo/day/yr): Age:	☐ 1 <18
Street address (apartment complex name/number):	County:	City: State: Zip Code:	
Prenatal Care covered by: ❑ Medicaid ❑ Private Insurance _____ ❑ No Insurance ❑ Other _____	Best time to contact me:	Phone #1 _____ Phone #2 _____	

I am giving written permission for release of the confidential information on this form and any information provided during my evaluation for services by Healthy Start to Healthy Start Providers, Healthy Start Coalitions, Healthy Families Florida, WIC, and my health care providers for the following purposes: program services, payment of claims for services, quality improvement of services or screening for program eligibility. This authorization shall remain in effect unless withdrawn in writing.

Patient Signature: _____ **Date:** _____

Please initial: _____ Yes _____ No I also give my permission for the release of any information on this form regarding mental health, TB, alcohol/drug abuse, STD, and HIV/AIDS.

✶ If you do not want to find out if you have any risks that could affect your health or your baby's health, complete the patient information section only and sign here: _____

PROVIDER ONLY

EDD (mo/day/yr):	LMP (mo/day/yr):	Pre-Pregnancy Ht: _____ Wt: _____ BMI: _____	☐ 1 < 19.8 ☐ 2 > 35.0
Provider's Name and Title:	Provider's ID:	Pregnancy Interval Less Than 18 Months? ❑ No	☐ 1 Yes
		Trimester at 1st Prenatal Visit? _____	☐ 1 2nd
Provider's Phone Number:	Provider's County:	Does patient have an illness that requires ongoing medical care? Specify illness: _____ ❑ No	☐ 2 Yes

Healthy Start Screening Score: _____ Check One: ❑ Referred to Healthy Start ❑ Not Referred to Healthy Start

Provider's/Interviewer's Signature and Title _____ Date (mo/day/yr)_____

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