

IS = INITIAL SCREENING QUESTIONS

FAMILY QUESTIONNAIRE

A. GENERAL INFORMATION

1. Mother's Name and Address: *[Please print.]*

Mother's Last Name First Middle

Street Address

City State Zip Code

2. Mother's date of birth: _____

IS 3. Mother's age: _____ < 18 = (70)
18 - 20 = (15)

4. Mother's Medicaid ID#: _____

5. HMO Name: _____

6. Primary Care Doctor/Clinic Name(s): _____

If none or unable to answer = (10)

7. Infant's Name: _____
Infant's Sex:
 Female
 Male

IS 8. Birth Weight: _____
If very low birth weight < 3.3 lbs. (1500 grams) = (70)
If low birth weight < 5.5 lbs. (2500 grams) = (30)
If birth weight > 10 lbs. (4540 grams) = (10)

IS 9. Birth Date: _____
If pre-term (gestational age < 37 weeks) = (70)

10. Home telephone number: _____
 No phone, or phone is often disconnected. = (15)

11. How can we contact you?

12. Are other agency staff visiting your home?
 No
 Yes
If yes, please list if known: _____

B. EMPLOYMENT

1. Are you employed?
 No
 Yes
If yes, what is your occupation?

2. If you are employed, how many hours do you usually work in a week? _____

3. What shift? (days, evenings, nights) _____

4. Do you feel your child care arrangements are safe and nurturing?
 No = (15)
 Yes

5. If returning to work/school, when will you go back?

IS 6. What was the last grade you finished? _____
8th grade or less = (40)
> 8th grade but < 12th grade = (15)

7. What are your sources of income? *(Please check all that apply.)*
 Parents
 Job
 Partner/spouse
 Unemployment benefits
 Child support payments
 Other: _____

Key: > = greater than
< = less than

Points (subtotal) _____

C. FAMILY FUNCTIONING

1. Are you:
 Married
 Single (includes, never married, separated, divorced, widowed) = (15)

2. Do you speak English?
 Very well
 A little = (10)
 Not at all = (15)

3. Do you read English?
 Very well
 A little = (10)
 Not at all = (15)

4. If of school age now, are you enrolled and do you attend school regularly?
 No = (10)
 Yes
 I am working on GED or have completed it
 I have dropped out = (10)

5. Have you in the past, or are you currently, receiving special or exceptional education services?
 No
 Yes = (10)

6. How many children do you have? _____
 If first child = (10)
 If > 4 children = (40)
 If > 2 children and mother is < 18 = (40)

7. Within the last 12 months, have any of your children been taken away from you?
 No
 Yes
 If yes, how many? _____ = (40)

8. Where do you live?
 House/Mobile Home
 Apartment Mobile Home
 With friends = (10)
 With other family members = (10)
 Homeless (including shelter, hotel/motel) = (70)
 Other, specify: _____

9. Who is currently living in your home?

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

10. Where you live now, do you have the following?

Yes	No
<input type="checkbox"/>	<input type="checkbox"/> Running water
<input type="checkbox"/>	<input type="checkbox"/> Hot water
<input type="checkbox"/>	<input type="checkbox"/> Working appliances (stove, refrigerator)
<input type="checkbox"/>	<input type="checkbox"/> Working bathroom/bathing facilities
<input type="checkbox"/>	<input type="checkbox"/> Working smoke detector
<input type="checkbox"/>	<input type="checkbox"/> Working fire extinguisher

 Each No = (5) Total points _____

11. Is there chipping paint inside/outside your home?
 No
 Yes = (10)

12. How many times have you moved in the last year?
 _____ > 2 times = (20)

13. Do you think you will need to move in the next 12 months?
 No
 Yes

14. How long have you been living in the present neighborhood?

15. What do you think of your neighborhood?
 It's a good place to live
 It's an okay place to live
 It's a bad place to live

16. What is the best thing about your neighborhood?

17. What is the worst thing about your neighborhood?

18. In the past two years, has your neighborhood become:
 A better place to live
 Stayed the same
 A bad place to live

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19. Do your children have a safe play area both inside and outside the home?

- No to either = (5)
- Yes

20. If not at home, where else can they play? [Please check all that apply.]

- Relatives Nowhere = (15)
- Park School playground
- Community Center Other: _____

21. Have you witnessed acts of violence in your neighborhood? If so, please describe these acts and the impressions they had on you:

22. Does your family own an automobile?

- No
- Yes

23. If yes, what is the condition of the automobile?

- Good
- Average
- Below Average

24. If you do not have an automobile, how do you get around?

- Get a ride from friends/relatives
- Use public transportation
- Walk
- Other: _____

25. How often do you have problems getting transportation?

- Never
- Occasionally
- Most of the time = (10)

26. If you use a car, does everyone use car seats or seat belts?

- Always
- Sometimes
- Never = (5)

Explain: _____

D. HEALTH

1. Where do you go for your regular health care (e.g., checkups, shots)?

- Family doctor/primary care provider/clinic
- Emergency room = (10)
- Other: _____

5. If the results require follow-up, has this occurred?

- No = (5)
- Yes

2. Have any of your children been hospitalized in the past 6 months?

- No
- Yes = (10)

If yes, for what types of problem(s):

6. Do you have a record of your children's immunizations?

- No = (5)
- Yes

7. If your child(ren) are 3 years or older, are they seeing a dentist?

- No = (5)
- Yes
- Not applicable

3. Have your children between 6 months and 6 years of age been tested for lead poisoning?

- No = (5)
- Yes = (5)
- Don't know = (5)
- Not applicable (Skip to #6)

8. How many months pregnant were you when you started seeing a medical provider (doctor, nurse practitioner, nurse midwife) for prenatal care?

_____ weeks or _____ months
13-15 weeks = (5) 15-23 weeks = (10) > 24 weeks = (20)

9. Did you receive prenatal care coordination services during this pregnancy?

- No
- Yes = (70)

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< = less than

10. How was your health during this pregnancy?
- Fine, no problems
 - Some problems (e.g., nausea, tiredness)
 - Serious problems (e.g., high blood pressure, diabetes) = (10)

Explain: _____

11. Did your baby stay in a "special care" nursery for more than one day?
- No
 - Yes = (10)
- If yes, how many? _____

12. Was this pregnancy:
- Planned = (5)
 - Unplanned = (40)
 - Result of sexual assault

13. How do you feel now that the baby is born?
- Happy
 - Unsure--a little bit happy, a little bit unhappy=(10)
 - Very upset about it = (20)

14. How does the father of the baby (or your partner) feel about the newborn?
- Happy
 - Unsure--a little bit happy, a little bit unhappy=(10)
 - Very upset about it = (20)

15. Do you have any history of prenatal or postpartum depression, raging, or "scary" thoughts about the baby?
- No
 - Yes = (40)

16. Do you plan to have another baby?
- No
 - Yes
- If yes, how soon? _____

17. Are you currently using birth control?
- No
 - Yes

18. Do you understand how to use the product?
- No = (5)
 - Yes

19. Have you experienced any problems getting the necessary supplies, medication or services?
- No
 - Yes = (5)

20. Do you, or your children receive SSI benefits or special services for a health problem?
- No
 - Yes = (20)
- If yes, who? _____
- What services? _____
- If receiving mental health related services = (50)

21. Are you or your children in a WIC Program?
- No
 - Yes
- If yes, where? _____
- _____

22. How are you currently feeding your baby?
- Breast-feed
 - Bottle feed
 - Both breast and bottle

23. At what age do you plan to start feeding cereal/baby food to your new baby?
- Birth-3 months = (5)
 - 4-6 months
 - I don't know = (5)

24. Are any of your children on a special diet or receiving special foods or drinks?
- No
 - Yes = (5)
- If yes, what? _____
- _____

25. Do you or your children ever eat non-food items, (e.g., dirt, sand, starch, paint chips)?
- No
 - Yes = (20)

26. Do you sometimes run out of food before you are able to buy more?
- No
 - Yes = (10)

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E. PARENTING ATTITUDES/SKILLS

1. How do you feel about the way you were raised as a child?
- Very positive: I had a happy childhood: my parents were very caring
 - Okay; my parents tried to do their best: parents caring
 - Negative: I received no nurturing = (10)
 - Very negative. I was punished frequently and received little or no nurturing = (40)
2. If you plan to parent differently than you were raised, how much support/encouragement will you get from your family/friends?
- A lot
 - A little
 - Very little = (10)
 - None = (20)
3. When you want advice about parenting, who do you go to? *[Please check all that apply.]*
- Parents
 - Friends
 - Doctor/nurse
 - Community "helping organizations"
 - I don't have anyone to ask = (10)
 - "It comes naturally" = (10)
 - Grandparents/family
 - Father of the child/partner
 - Books/magazines
4. Do you ever feel your infant cries or is demanding "on purpose" or just to "irritate you"?
- No
 - Yes = (40)
- If yes, please explain: _____
5. At what age do you think your baby will:
- Be potty trained _____
 - Sleep all night _____
 - Begin to walk _____
- If answer is unrealistic = (15)
6. Do you have an adequate supply or access to toys, books, games, or other play equipment?
- No
 - Yes
7. When your children are playing or having fun, do you join them?
- Most of the time
 - Occasionally = (5)
 - Rarely = (10)
8. How helpful is the child's father (or your partner) in raising this child and other children in your household?
- Very helpful
 - Helps when requested to help
 - Not helpful = (10)
9. Finish this sentence.
I think my/our children are: _____

- Use of strong negatives such as, interfere with my activities, too demanding, too much work, ugly, stupid, bad.* = (20)

F. TOBACCO, ALCOHOL AND OTHER DRUGS

1. Do you or anyone else in your household smoke?
- No
 - Yes
2. If yes, do you have "rules" governing when and where not to smoke?
- No = (20)
 - Yes
- I need to ask you a few questions about drinking and drug use. It will help us take better care of you and your children. Be sure to include beer, wine and liquor in your answers to these questions.*
3. How many drinks does it take to make you feel high? _____ > 2 = (20)
- I never drink
4. How much can you hold? _____ > 2 = (20)
- I never drink
 - I don't know
5. Have people annoyed you by criticizing your drinking?
- No
 - Yes = (20)
 - I never drink

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6. Have you ever felt you ought to cut down on your drinking?
- No
 - Yes = (20)
 - I never drink
7. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?
- No
 - Yes = (20)
 - I never drink

8. In the past 12 months, have you injected a non-prescribed drug or used any other street drugs (e.g., marijuana, hash, cocaine, heroin, crack, amphetamines)?
- No
 - Yes = (70)

9. Does anyone who is involved in caring for your children abuse alcohol or other drugs?
- No
 - Yes = (20)
- If yes, explain: _____

G. PERSONAL SUPPORT/COPING SKILLS

1. How do you deal with stress and anger? [Please check all that apply.]
- Talk it out
 - Calm down by taking a walk, doing some activity
 - Not talk about it at all = (5)
 - Take it out on somebody by yelling = (5)
 - Get violent (e.g., hitting, threatening with object or weapon) = (50)
 - Have a drink or get high to calm my nerves = (20)
 - Other: _____

2. How does the father of the baby (or your partner) deal with stress and anger? [Please check all that apply.]
- Talk it out
 - Calm down by taking a walk, doing some activity
 - Not talk about it at all = (5)
 - Take it out on somebody by yelling = (5)
 - Get violent (e.g., hitting, threatening with object or weapon) = (50)
 - Have a drink or get high to calm his nerves = (20)
 - Other: _____

3. Have you, or your children, ever been emotionally or verbally abused by the father of the baby, your partner, or someone close to you?
- No
 - Yes = (20)

4. Does the father of the baby (or your partner) physically, verbally, or emotionally, abuse you or your children?
- No
 - Yes = (70)

5. Have you or other household members been raped or forced to have sex against your/their will?
- No
 - Yes = (30)

6. Does the abuser(s) still have access to you or your children?
- No
 - Yes = (40)

7. Has anyone in your immediate household (parent, spouse, partner, sibling) been incarcerated/jailed for a crime in the past year or more than 3 times in the past 5 years?
- No
 - Yes = (40)

8. Are you afraid of the father of the baby, your partner or anyone else in your household?
- No
 - Yes = (20)

9. Is there a gun in your home?
- No
 - Yes = (10)

10. If yes, are the guns unloaded and stored in a locked place?
- No = (15)
 - Yes

11. How many people do you know well enough to visit with in your neighborhood?
- _____ = (5)
- None

12. How often do you spend time with friends or relatives?
- _____ = (10)
- Never

Key: > = greater than
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13. Do you have someone you can talk with when you need to?
 No = (20)
 Yes

14. Do you find yourself feeling lonely?
 Quite often
 Sometimes
 Almost never

15. Is there anyone you can count on in case of an emergency?
 No = (10)
 Yes

16. Is there someone who could help you for as long as you needed their help?
 No
 Yes

17. Are you known or do you think of yourself as a resource to others?
 No
 Yes

18. How often do you go to neighborhood activities such as spiritual ceremonies, support groups or "club" functions?
 Never = (5)

19. How would you describe yourself to someone who does not know you?

20. Does your family have special traditions that they observe?
 No
 Yes
 If yes, explain:

21. Tell me about your family's strengths.

 None = (10)

22. Which of these things worry you a lot? [Check the ones that are big problems.]

- Money problems = (2)
- Transportation = (2)
- My job = (2)
- My partner's job, or unemployment = (2)
- Caring for this baby/my other children = (2)
- Housing problems/getting evicted = (2)
- Getting child care = (2)
- My physical or mental health/safety = (2)
- My drinking/drug use = (2)
- My partner's drinking or drug use = (2)
- My relationship with my partner = (2)
- My child's relationship with his/her father = (2)
- My partner is in jail = (2)

23. Would you like more help or information with any of these things?

- Discipline
- Child development
- Parenting skills
- Playing with your children
- Health Issues
- Employment Training
- Coping with stress
- Family planning/Pregnancy prevention
- Community resources for parents

 Staff Signature/Assessment Date

 Staff Signature/Reassessment Date

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Points (subtotal) _____
 Total (all pages) _____