FATHER AND OTHER ENROLLMENT

HSID: __ __ __ __ - __ __ __ __ - (last two digits must be 50 for father, 60 for others)
Screening Date: ___ /___ /_____ Staff_____

Client First Name: _____ Client Last Name_____

Date of birth (mm/dd/yy) ___ /___/_____ **populated.** Current Age _____ **populated**

*Participation Status:
☐Primary Adult associated with infant/child - (List First & Last Name of all Enrolled Children)
_____

☐Accompanying Other Primary- (List Primary) _____

☐Other (Explain)_____

Relationship to Child: ▯ Father ▯ Other, (specify) _____

*If <age 24, meets CSHCN criteria? Children with Special Health Care needs ☐Yes ☐No
(**This question will only appear in data system if client is age eligible)**

FOOD

*Enrolled in WIC: ▯ Yes ▯ No. *Needs Nutrition Information: ▯ Yes ▯ No

*In the last 12 months, did you (or other adults in your household) ever cut the size of your meals or skip meals because there was not enough money or food?
▯ Yes ▯ No ▯ Refused

If Yes, how often did this happen?
▯ Almost every month. ▯ Some months but not very much. ▯ In only 1 or 2 months

Do you receive a Bridge Card (food stamps)? ☐Yes ☐No ☐Refused

TRANSPORTATION

*Do you have access to reliable transportation? ☐Yes ☐No
If No, please check all concerns that apply. ▯ Potential Unavailability ▯ Unreliable ▯ Not affordable

*Needs transportation assistance ▯ Yes ▯ No

HOUSING

*How many times have you moved in the last 12 months? ☐0 ☐1 ☐2 ☐3 ☐4 or more

*Do you currently have any concerns or worries about your housing situation? ☐Yes ☐No

If Yes, check all that apply. If no skip to next question.

- No place to live, no regular nighttime residence
- Eviction or being forced to move out
- Affordability of current house or apartment
- Safety of house/apartment
- Strained relations with other(s) in household
- Sanitation/waste removal
- House or apartment is too crowded
- Pest Control
- Safety of neighborhood
- Ease of access into home
- Code violations
- Ventilation/air conditioning
- Lack of continuous function basic utility service (e.g. heat, electricity)

TELEPHONE

*How often do you have access to a telephone to make and receive calls where you live?
 Always Sometimes Never

PHYSICAL ACTIVITY

BMI Calculation: Feet_____ Inches: _____ Weight: _____ BMI: ____ System generated_

In the past 30 days have you participated in any leisure time physical activity, such as walking, biking, swimming or other sports, ect? ☐Yes ☐ No

In an average week, how often do you participate in at least 30 minutes of physical activity?
☐Zero times ☐Once ☐2-3 times ☐4 times ☐5 or more

ORAL HEALTH

How long has it been since you had a dental exam or cleaning?

☐Within the past year
☐Within the past 2 years
☐Within the past 5 years
☐ More than 5 years
☐Don't know/not sure
☐ Never

MEDICAL

Have you had an annual check- up visit to your primary care provider in the last 12 months?
☐Yes ☐No ☐Refused

Medical Conditions	**Have been treated for or told that you have**	**Date of last visit to health care provider about this condition**	**Follow up needed? Y/N**
Asthma	☐Yes ☐No		☐Yes ☐No
Group B Strep or Bacterial Vaginosis	☐Yes ☐No		☐Yes ☐No
Recurring Vag Infections	☐Yes ☐No		☐Yes ☐No
Sexually transmitted infection:	☐Yes ☐No		☐Yes ☐No
HIV/AIDS	☐Yes ☐No		☐Yes ☐No
Hepatitis B or C	☐Yes ☐No		☐Yes ☐No
Hypertension	☐Yes ☐No		☐Yes ☐No
High cholesterol	☐Yes ☐No		☐Yes ☐No
Diabetes: Non-insulin dependent Insulin dependent Gestational (if Hx of GDM ask about BS screen)	 ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No		 ☐Yes ☐No ☐Yes ☐No ☐Yes ☐No
Family Hx Breast Cancer	☐Yes ☐No		☐Yes ☐No
Fecal Occult blood test (FOBT)/colon cancer screening	☐Yes ☐No		☐Yes ☐No
Mental Illness: depression, bipolar, other	☐Yes ☐No		☐Yes ☐No
Other: (List)	☐Yes ☐No		☐Yes ☐No

SUBSTANCE USE

*Are you currently in treatment for Alcohol, Drug, or Substance Use? ☐Yes ☐No ☐Refused

*Does anyone in your household use tobacco products in the home? ☐Yes ☐No ☐Refused

Do you currently smoke cigarettes? ☐Yes ☐No ☐Refused
If Yes, about how many do you smoke per day? _____
Have you cut down in the past year? ☐Yes ☐No ☐Refused
Are you seriously considering quitting? ☐Yes ☐No ☐Refused

*In the past 12 months, how often have you?

a. Used any tobacco product (for example, cigarettes, e-cigarettes, cigars, pipes, or smokeless tobacco)?
☐Daily or Almost Daily
☐Weekly
☐Monthly
☐Less than Monthly
☐Never
☐Declined to answer

b. For **women**: Had 4 or more drinks containing alcohol in one day?
For **men**: Had 5 or more drinks containing alcohol in one day?
One standard drink is about 1 small glass of wine 5oz, 1 beer (12 oz), or 1 single shot of liquor

☐Daily or Almost Daily
☐Weekly
☐Monthly
☐Less than Monthly
☐Never
☐Declined to answer

c. Used Marijuana?
☐Daily or Almost Daily
☐Weekly
☐Monthly
☐Less than Monthly
☐Never
☐Declined to answer

d. Used any illicit drugs including cocaine or crack, heroin, methamphetamine (crystal meth), hallucinogens, ecstasy/MDMA?
☐Daily or Almost Daily
☐Weekly
☐Monthly
☐Less than Monthly
☐Never
☐Declined to answer

e. Used any prescription medications just for the feeling, more than prescribed, or that were not prescribed to you?
☐Daily or Almost Daily
☐Weekly
☐Monthly
☐Less than Monthly
☐Never
☐Declined to answer

DEPRESSION SCREENING (PHQ 2)

*Over the last 2 weeks, how often have you been bothered by the following problems?

Staff: Read each item to participant, and check one response for each item. A total score of 3 or more indicates additional screening and possible referral is needed.

*a. Little interest or pleasure in doing things
☐Not at all (0)
☐Several days (1)
☐More than half the days (2)
☐Nearly every day (3)
☐Declined to answer (0)

*b. Feeling down, depressed, or hopeless
☐Not at all (0)
☐Several days (1)
☐More than half the days (2)
☐Nearly every day (3)
☐Declined to answer (0)

Total Score: _____ [system generated]

*Staff: Please indicate which response best reflects the need for referral and/or follow-up services related to possible depression.

☐Participant's total score was less than 3 and so did not indicate a need for referral

☐Participant's total score of 3 or more indicates that additional screening and referral is needed and referral WAS PROVIDED. ***Staff: Be sure to document referral on encounter form.***

☐Participant's total score of 3 or more indicates that additional screening and referral is needed but referral WAS NOT PROVIDED because: Client is already receiving services for possible depression

☐Participant's total score of 3 or more indicates that additional screening and referral is needed but referral WAS NOT PROVIDED because: Client declined referral

STRESS (PERCEIVED STRESS SCALE)

*In the last month, how often have you felt that you were unable to control the important things in your life?

 Never (0)
 Almost Never (1)
 Sometimes (2)
 Fairly Often (3)
 Very Often (4)

*In the last month, how often have you felt confident about your ability to handle your personal problems?
 Never (4)
 Almost Never (3)
 Sometimes (2)
 Fairly Often (1)
 Very Often (0)

*In the last month, how often have you felt that things were going your way?
 Never (4)
 Almost Never (3)
 Sometimes (2)
 Fairly Often (1)
 Very Often (0)

*In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?
 Never (0)
 Almost Never (1)
 Sometimes (2)
 Fairly Often (3)
 Very Often (4)

Higher Score, Higher the stress:
Total Perceived Stress Score (0-16): _____

ABUSE/VIOLENCE

Are you in a relationship now? ☐Yes ☐No ☐Refused

Do you feel safe in your present relationship? ☐Yes ☐No ☐Refused

*As a child have you ever been involved with Children's Protective Services?
☐Yes ☐No ☐Refused

*Have you ever been involved with Children's Protective Services with any of your children?
☐Yes ☐No ☐Refused
*During the past 12 months, has anyone: (Check all that apply)

a. Threatened you or made you feel unsafe in some way
☐Current of Former Intimate Partner
☐Other Family Member

☐Someone Else
☐No-one
☐Declined to answer

b. Made you feel frightened for your safety or your family's safety because of their anger or threats?
☐Current of Former Intimate Partner
☐Other Family Member
☐Someone Else
☐No-one
☐Declined to answer

c. Tried to control your daily activities, for example, control who you could talk to or where you could go?
☐Current of Former Intimate Partner
☐Other Family Member
☐Someone Else
☐No-one
☐Declined to answer

d. Pushed, hit, slapped, kicked, choked, or physically hurt you in any other way?
☐Current of Former Intimate Partner
☐Other Family Member
☐Someone Else
☐No-one
☐Declined to answer

e. Forced you to take part in touching or any sexual activity when you did not want to?
☐Current of Former Intimate Partner
☐Other Family Member
☐Someone Else
☐No-one
☐Declined to answer

*Staff: Indicate IPV screening status below:

☐Screening completed (all questions 19a-e answered)

☐Screening not completed due to:
- ☐Presence of partner
- ☐Presence of Family Member
- ☐Participant declined to answer one or more questions
- ☐Other Reason, Specify_____

COMMENTS: