



Help your baby have a healthy start in life!



Please answer the following questions to find out if anything in your life could affect your health or your baby's health. Your answers are confidential. You may qualify for free services from the Healthy Start Program or the Healthy Families Program, no matter what your income level is! (Please complete in ink.)*

Today's Date: _____

YES NO

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

11. What race are you? Check one or more.

White Black Other _____

12. In the last month, how many alcoholic drinks did you have per week?

_____ drinks did not drink

13. In the last month, how many cigarettes did you smoke a day? (a pack has 20 cigarettes)

_____ cigarettes did not smoke

14. Thinking back to just before you got pregnant, did you want to be.....?

pregnant now pregnant later not pregnant

15. Is this your first pregnancy?

Yes No If no, give date your last pregnancy ended:
Date: (month/year)_____

16. Please mark any of the following that have happened.

- Had a baby that was not born alive
- Had a baby born 3 weeks or more before due date
- Had a baby that weighed less than 5 pounds, 8 ounces
- None of the above

PATIENT INFORMATION	Name: First _____ Last _____ M.I. _____ Social Security Number: _____ Date of Birth (mo/day/yr): _____ 17. Age: _____ <input type="checkbox"/> < 18
	Street address (apartment complex name/number): _____ County: _____ City: _____ State: _____ Zip Code: _____
	Prenatal Care covered by: <input type="checkbox"/> Medicaid <input type="checkbox"/> Private Insurance _____ <input type="checkbox"/> No Insurance <input type="checkbox"/> Other _____ Best time to contact me: _____ Phone #1 _____ Phone #2 _____

I authorize the exchange of my health information between the Healthy Start Program, Healthy Start Providers, Healthy Start Coalitions, Healthy Families Florida, WIC, Florida Department of Health, and my health care providers for the purposes of providing services, paying for services, improving quality of services or program eligibility. This authorization remains in effect until revoked in writing by me.

Patient Signature: _____ Date: _____

Please initial: _____ Yes _____ No I also authorize specific health information to be exchanged as described above, which includes any of my mental health, TB, alcohol/drug abuse, STD, or HIV/AIDS information.

* If you do not want to participate in the screening process, please complete the patient information section only and sign below:

Signature: _____ Date: _____

PROVIDER ONLY	LMP (mo/day/yr): _____ EDD (mo/day/yr): _____ 18. Pre-Pregnancy: Wt: _____ lbs. Height: _____ ft. _____ in. BMI: _____ <input type="checkbox"/> < 19.0 <input type="checkbox"/> > 35.0
	Provider's Name: _____ Provider's ID: _____ 19. Pregnancy Interval Less Than 18 Months? <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes
	Provider's Phone Number: _____ Provider's County: _____ 20. Trimester at 1st Prenatal Visit? _____ <input type="checkbox"/> 1st <input type="checkbox"/> 2nd
	21. Does patient have an illness that requires ongoing medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Healthy Start Screening Score: _____ Check One: <input type="checkbox"/> Referred to Healthy Start. If score <6, specify: _____ <input type="checkbox"/> Not Referred to Healthy Start.
Provider's/Interviewer's Signature and Title _____ Date (mo/day/yr) _____	