



Maternal Health Intake

Client ID: _____

Admission ID: _____

Client's name (first, middle, last) _____ Maiden name _____

Client alias _____ Alias Client ID _____

Birth date ____/____/____ Social Security # _____ Other IDs: _____

ID Number	ID Type

Street address _____ Apt# _____ County _____

City _____ State _____ Zip code _____

Home phone _____ Work phone _____

Message phone _____ Message place _____ Message contact _____

Emergency contact _____ Phone _____ Relationship _____

Primary Race: (enter option from race table below) _____

Race: (Check all that apply)		
<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Black	<input type="checkbox"/> unknown
<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Other Pacific	<input type="checkbox"/> other specify _____
	<input type="checkbox"/> White	

Is participant of Hispanic/Latino descent? yes no

Country of Origin: (if Hispanic/Latino)	<input type="checkbox"/> Central America	<input type="checkbox"/> Mexico	<input type="checkbox"/> South America	<input type="checkbox"/> other specify _____
	<input type="checkbox"/> Cuba	<input type="checkbox"/> Puerto Rico	<input type="checkbox"/> Unknown	

Ethnicity:	<input type="checkbox"/> African American	<input type="checkbox"/> Asian (not Vietnamese)	<input type="checkbox"/> Haitian	<input type="checkbox"/> Somalian
	<input type="checkbox"/> African (not Sudanese)	<input type="checkbox"/> Asian (Vietnamese)	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> unknown
	<input type="checkbox"/> African (Sudanese)	<input type="checkbox"/> Bosnian	<input type="checkbox"/> Jamaican	<input type="checkbox"/> other specify _____
	<input type="checkbox"/> American	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	
	<input type="checkbox"/> Croatian	<input type="checkbox"/> Micronesian		

Languages spoken:	<input type="checkbox"/> American Sign Language	<input type="checkbox"/> English	<input type="checkbox"/> Sudanese	<input type="checkbox"/> other specify _____
	<input type="checkbox"/> Bosnian	<input type="checkbox"/> Serbian	<input type="checkbox"/> Vietnamese	
	<input type="checkbox"/> Chinese	<input type="checkbox"/> Spanish	<input type="checkbox"/> unknown	

Is English the primary language? yes no unknown

Is a translator needed? yes no unknown If yes, what language? _____

Date of contact: _____

How did client hear of services? (choose all that apply)

<input type="checkbox"/> birthright	<input type="checkbox"/> juvenile court officer	<input type="checkbox"/> hospital (specify) _____
<input type="checkbox"/> care coordinator	<input type="checkbox"/> medical clinic	<input type="checkbox"/> other agency (specify) _____
<input type="checkbox"/> church	<input type="checkbox"/> other participant	<input type="checkbox"/> media (specify) _____
<input type="checkbox"/> daycare	<input type="checkbox"/> primary care provider	<input type="checkbox"/> literature (specify) _____
<input type="checkbox"/> DHS	<input type="checkbox"/> school nurse/counselor	<input type="checkbox"/> outreach (specify) _____
<input type="checkbox"/> door to door	<input type="checkbox"/> shelter	<input type="checkbox"/> other (specify) _____
<input type="checkbox"/> education/school/AEA	<input type="checkbox"/> walk-in /self-referral	
<input type="checkbox"/> family planning	<input type="checkbox"/> WIC	
<input type="checkbox"/> friend/relative	<input type="checkbox"/> unknown	

Will services be provided? yes no Program? Maternal Health Women's Health Post-partum visit only Dental visit only

If no, reason not served:	<input type="checkbox"/> eligibility guidelines not met	<input type="checkbox"/> not pregnant	<input type="checkbox"/> other
	<input type="checkbox"/> out of service area	<input type="checkbox"/> services refused	specify _____

Client consent form signed? <input type="checkbox"/> yes <input type="checkbox"/> no	Date signed: ____/____/____
Subcontractor assigned: _____	County Assigned _____

Client Name: _____ Birth Date: _____ Medicaid ID: _____

Primary Payment Source: (enter option from payment source table below) _____

Secondary Payment source:
(check all that apply)

<input type="checkbox"/> county funds	<input type="checkbox"/> Medipass	<input type="checkbox"/> SSI	<input type="checkbox"/> other specify _____
<input type="checkbox"/> eligible/not receiving Title XIX	<input type="checkbox"/> OB indigent	<input type="checkbox"/> Title V	
<input type="checkbox"/> HawkI	<input type="checkbox"/> presumptive eligibility	<input type="checkbox"/> uninsured	
<input type="checkbox"/> Medicare	<input type="checkbox"/> private insurance	<input type="checkbox"/> unknown	
<input type="checkbox"/> Medicaid/Title XIX	<input type="checkbox"/> self-pay/sliding scale	<input type="checkbox"/> non-billable	

WIC certified at admission? yes no unknown

Employment:

<input type="checkbox"/> full time	<input type="checkbox"/> student	<input type="checkbox"/> disabled	<input type="checkbox"/> other
<input type="checkbox"/> part time	<input type="checkbox"/> self-employed	<input type="checkbox"/> temporary	<input type="checkbox"/> unknown
<input type="checkbox"/> unemployed	<input type="checkbox"/> homemaker		

Work Hours:

<input type="checkbox"/> day	<input type="checkbox"/> nights
<input type="checkbox"/> evening	<input type="checkbox"/> varies

Current marital status:

<input type="checkbox"/> divorced	<input type="checkbox"/> parent with partner	<input type="checkbox"/> single	<input type="checkbox"/> unknown
<input type="checkbox"/> married	<input type="checkbox"/> separated	<input type="checkbox"/> widowed	

Highest grade participant completed:

<input type="checkbox"/> 8th grade or less	<input type="checkbox"/> high school graduate	<input type="checkbox"/> college degree
<input type="checkbox"/> 9th grade	<input type="checkbox"/> GED	<input type="checkbox"/> technical training
<input type="checkbox"/> 10th grade	<input type="checkbox"/> some college	<input type="checkbox"/> other
<input type="checkbox"/> 11th grade		

How many children does client have? _____ Age range of children: _____

How many children are living in the home? _____

Father Information

Record name of baby's father and choose the code from the tables below to indicate race, ethnicity, relationship and insurance status. If the father's name is not available enter "unknown".

Name: _____

Race	Ethnicity	Relationship?	Living with participant?	Involved with pregnancy/child?	Employed?	Insurance status?
code from list	code from list	code from list	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown	code from list

<p>Race</p> <p>(1) American Indian/Alaska Native (2) Asian (3) Black (4) Native Hawaiian/Other Pacific (5) White (6) unknown (7) other specify _____</p>	<p>Ethnicity</p> <p>(3) African American (1) African (not Sudanese) (2) African (Sudanese) (4) American (5) Asian (not Vietnamese) (6) Asian (Vietnamese) (7) Bosnian (8) Chinese (9) Croatian (10) Haitian (11) Hispanic/Latino (12) Jamaican (13) Korean (16) Micronesian (12) unknown (13) other specify _____</p>	<p>Relationships</p> <p>(1) spouse (2) significant other (3) other relative (4) other</p>	<p>Insurance status</p> <p>(2) county funds (3) eligible/no Title XIX (6) HawkI (8) Medicaid/Title XIX (9) Medicare (10) Medipass (11) OB Indigent (12) presumptive eligibility (13) private insurance (14) self-pay/sliding scale (15) SSI (17) Title V (18) uninsured (19) unknown (20) other</p>
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Comments: _____

Client Name: _____ Birth Date: _____ Medicaid ID: _____

Previous Pregnancies

Last pregnancy end date: ____/____/____

How many previous pregnancies? _____

How many live births? _____

How many fetal deaths? _____

How many neonatal deaths? _____

How many spontaneous abortions? _____

How many therapeutic abortions? _____

Pregnancy Information

Has the client been seen at any other agency with this pregnancy? yes no unknown

Was this a planned pregnancy? yes no unknown

Was client using birth control? yes no unknown

Birth control type:	<input type="checkbox"/> birth control pills	<input type="checkbox"/> IUD	<input type="checkbox"/> quarterly injection	<input type="checkbox"/> tubal ligation
	<input type="checkbox"/> condom	<input type="checkbox"/> monthly injection	<input type="checkbox"/> rhythm method	<input type="checkbox"/> vasectomy
	<input type="checkbox"/> diaphragm	<input type="checkbox"/> Norplant	<input type="checkbox"/> spermicidal foam or insert	<input type="checkbox"/> none
	<input type="checkbox"/> female condom	<input type="checkbox"/> patch	<input type="checkbox"/> three month injection	<input type="checkbox"/> other
				specify other _____

Due date ____/____/____

Date of last menses ____/____/____

When was pregnancy first identified? 1st trimester 2nd trimester 3rd trimester unknown

Is client receiving prenatal care? yes no unknown

When was first care received? pre conception 1st trimester 2nd trimester 3rd trimester no care

How many prenatal appointments have been kept? _____

Practitioner providing prenatal care:	<input type="checkbox"/> Advanced Registered Nurse Practitioner	<input type="checkbox"/> Lay Midwife	<input type="checkbox"/> unknown
	<input type="checkbox"/> Certified Nurse Midwife	<input type="checkbox"/> Obstetrician	<input type="checkbox"/> other
	<input type="checkbox"/> Family Practice Physician		specify _____

Provider's name: _____

Attending childbirth education classes? yes no unknown

Attending parenting education classes? yes no unknown

Is client taking prenatal vitamins, including folic acid? yes no unknown

How does mother feel about pregnancy? indifferent positive negative

Client Name: _____ Birth Date: _____ Medicaid ID: _____

Maternal Health and Risk Assessment

Allergies? yes no unknown Specify: _____

Is client taking regular medications? yes no unknown

What medications? antibiotics anti seizure meds other
 antidepressants pain meds specify _____

Smoke cigarettes? yes no unknown

How many cigarettes per day? <1 5-10 1 pack more than 2 packs
 1-5 10-20 1-2 packs unknown

Has the client used alcohol in the three months prior to pregnancy? yes no unknown

Is the client currently using alcohol? yes no unknown

How often? never less than 1 drink/week 2-6 drinks/week 1 drink/day more than 1 drink/day

Has the client used illicit drugs in the three months prior to pregnancy? yes no unknown client declines

Is the client currently using illicit drugs? yes no unknown client declines

What drugs? cocaine crack marijuana unknown
 heroin methamphetamine other specify _____

Has client been tested for HIV/AIDs? yes no unknown client declines

Were results positive? yes no unknown client declines

Does client have STDs or a history of STDs? yes no unknown client declines

What STDs? chlamydia hepatitis syphilis other specify _____
 cytomegalovirus herpes trichomonas
 gonorrhoea HPV unknown

Is client being treated for STDs? yes no unknown client declines

Is partner being treated for STDs? yes no unknown client declines

Was client screened for domestic violence? yes no unknown

Was client screened for substance abuse? yes no unknown

Was client screened for depression? yes no unknown

Is client a medical risk? yes no unknown

Is client a nutritional risk? yes no unknown

Is client a psychosocial risk? yes no unknown

Oral Health Information

Does client have regular dentist? yes no unknown Name of dentist: _____

When was last dentist visit? Within 1 year 1-3 years ago More than 3 years ago Never seen a dentist Unknown

Barrier(s) to dental care: Cost Dentist will not accept Medicaid Transportation Office Hours Fear None Other
(specify) _____

Dental Insurance: Hawk-i private dental insurance other
 Medicaid/Title XIX self-pay specify _____

Does client have any oral concerns or problems? yes no

Specify: _____

Dental comments: _____

General comments: _____

Intake form completed by:		
Data entered by:		
Quality assurance inspection:		