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?	☐	☐ 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.....?

☐ pregnant now ☐ pregnant later ☐ 1 not pregnant

15. Is this your first pregnancy?

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

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

☐ 3 Had a baby that was not born alive
☐ 3 Had a baby born 3 weeks or more before due date
☐ 3 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: ☐ 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 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: _____	☐ 1 < 19.8 ☐ 2 > 35.0
Provider's Name:	Provider's ID:	19. Pregnancy Interval Less Than 18 Months? ☐ N/A ☐ No	☐ 1 Yes
		20. Trimester at 1st Prenatal Visit? _____	☐ 1 2nd
Provider's Phone Number:	Provider's County:	21. 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. If score <6, specify:** _____ **☐ Not Referred to Healthy Start.**		
Provider's/Interviewer's Signature and Title _____ **Date (mo/day/yr)** _____			

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PINK—Retained in patient's record GREEN—Patient's Copy