

**COMPREHENSIVE PERINATAL SERVICES PROGRAM  
INITIAL PERINATAL RISK ASSESSMENT**

DATE \_\_\_\_\_ NAME \_\_\_\_\_ AGE \_\_\_\_\_ EDC \_\_\_\_\_

(Note: Medical history and anthropometric information is available on OB-Medical History forms.)

(Note: Complete Diet Recall at this time if not already completed.)

Please answer the following questions by marking a  in the  or by writing in the blank space

- |   |   |
|---|---|
| <p>1. What languages do you speak?    <input type="checkbox"/> English                    <input type="checkbox"/> Spanish                    Other _____</p> <p>2. What languages do you read?    <input type="checkbox"/> English                    <input type="checkbox"/> Spanish                    Other _____</p> <p>3. How many years of school have you finished? _____ years</p> <p>4. Do you have a job?                    <input type="checkbox"/> Yes <input type="checkbox"/> No                    What kind of work? _____</p> <p>5. Does your partner have a job?    <input type="checkbox"/> Yes <input type="checkbox"/> No                    What kind of work? _____</p> <p>6. Are you on a special diet?        <input type="checkbox"/> Yes <input type="checkbox"/> No                    If you are on a special diet, what kind?<br/> <input type="checkbox"/> Weight loss    <input type="checkbox"/> low fat/low cholesterol    <input type="checkbox"/> low salt                    <input type="checkbox"/> diabetic<br/> Other _____</p> <p>7. Are you vegetarian?                    <input type="checkbox"/> Yes <input type="checkbox"/> No<br/> If yes, do you use milk products (milk, cheese, yogurt) and / or eggs?    <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Are you allergic to any foods, or do you try not to eat any foods?<br/> <input type="checkbox"/> Yes <input type="checkbox"/> No                    If yes, what _____</p> <p>9. How many cups, glasses or cans of these do you drink every day?<br/> water _____    milk _____                    juice _____                    diet soda _____<br/> Punch/kool aid _____    coffee _____                    tea _____                    soda _____</p> <p>10. How many times a day do you usually eat (including snacks)? _____</p> <p>11. Do you have<br/> nausea    <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> vomiting                                        <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> poor appetite                                <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> weight loss                                    <input type="checkbox"/> Yes <input type="checkbox"/> No                    How many pounds? _____<br/> diarrhea                                        <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> constipation                                 <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> heartburn                                      <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> <input type="checkbox"/> other _____</p> <p>12. What home remedies, food supplements, or herbs are you taking?<br/> Ginseng                                        <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> Ma Huang (Ephedra)                      <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> Manzanilla (Chamomile)                <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> Hierba buena (Peppermint)            <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> <input type="checkbox"/> other _____</p> <p>13. During this pregnancy, have you eaten<br/> maicena (cornstarch)                    <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> laundry starch                               <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> dirt or clay                                    <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> paste or plaster                              <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> freezer frost                                 <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> <input type="checkbox"/> other _____</p> <p>14. During this pregnancy, are you taking<br/> aspirin                                         <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> cold medicine                                <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> allergy/sinus medicine                  <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> diet pills                                        <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> prenatal vitamins                          <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> other vitamins                               <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> iron pills                                       <input type="checkbox"/> Yes <input type="checkbox"/> No                    How often? _____<br/> <input type="checkbox"/> other _____</p> | <p>1.    <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H</p> <p>2.    <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H</p> <p>3.    <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H</p> <p>4.    <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H</p> <p>5.    <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H</p> <p>6.    <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H</p> <p>7.    <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H</p> <p>8.    <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H</p> <p>9.    <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H</p> <p>10. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H</p> <p>11. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H</p> <p>12. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H</p> <p>13. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H</p> <p>14. <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H</p> |
|---|---|

**PROVIDER INFORMATION:**

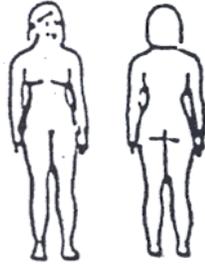
Provider Name: \_\_\_\_\_

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- |     |   |   |   |  |   |                                      |  |  |
|-----|---|---|---|--|---|--------------------------------------|--|--|
| 15. | How do you plan to feed your baby?  | <input type="checkbox"/> Breast             | <input type="checkbox"/> Bottle             | <input type="checkbox"/> Both            | <input type="checkbox"/> not sure         | 15.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
| 16. | Have you breastfed a baby before?   | <input type="checkbox"/> Yes                | <input type="checkbox"/> No                 |  |   | 16.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
| 17. | a. Where are you living right now?  | <input type="checkbox"/> House              | <input type="checkbox"/> Apartment          | <input type="checkbox"/> Motel           |   | 17.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
|     | <input type="checkbox"/> in a friend's house or apartment   | <input type="checkbox"/> Car                | <input type="checkbox"/> Street             | <input type="checkbox"/> other _____     |   |                                      |  |  |
|     | b. How long have you lived there?   | _____                                       |   |  |   |                                      |  |  |
| 18. | How many people live with you?  | <input type="checkbox"/> no one             | <input type="checkbox"/> 1-3 others         | <input type="checkbox"/> 4-6 others      | <input type="checkbox"/> 7 or more others | 18.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
|     | Who lives with you?   | <input type="checkbox"/> live alone         | <input type="checkbox"/> husband/partner    | <input type="checkbox"/> parents         | <input type="checkbox"/> in-laws          |                                      |  |  |
|     |   | <input type="checkbox"/> your children      | <input type="checkbox"/> other's children   | <input type="checkbox"/> friends         | <input type="checkbox"/> other family     |                                      |  |  |
|     | How many children are in your household?  | _____                                       |   |  |   |                                      |  |  |
| 19. | If you are worried about something, who do you talk to?   | _____                                       |   |  |   | 19.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
|     | <input type="checkbox"/> husband/partner  | <input type="checkbox"/> parents            | <input type="checkbox"/> grandparents       | <input type="checkbox"/> other relatives |   |                                      |  |  |
|     | <input type="checkbox"/> friend   | <input type="checkbox"/> other person _____ |   |  |   |                                      |  |  |
| 20. | Do you have (✓ <input type="checkbox"/> if yes)   | <input type="checkbox"/> electricity        | <input type="checkbox"/> hot water          | <input type="checkbox"/> refrigerator    | <input type="checkbox"/> stove or oven    | 20.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
|     |   | <input type="checkbox"/> transportation     | <input type="checkbox"/> a telephone        | <input type="checkbox"/> heating         |   |                                      |  |  |
| 21. | Are you usually able to (✓ <input type="checkbox"/> if yes)   | <input type="checkbox"/> buy enough food    | <input type="checkbox"/> pay rent           | <input type="checkbox"/> pay other bills |   | 21.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
| 22. | Have you ever had trouble finding a doctor, or getting medical help for yourself or family?                         | <input type="checkbox"/> Yes                | <input type="checkbox"/> No                 |  |   | 22.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
|     | If yes, explain _____   |   |   |  |   |                                      |  |  |
| 23. | Are you on WIC (Women, Infants & Children) Program?   | <input type="checkbox"/> Yes                | <input type="checkbox"/> No                 |  |   | 23.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
| 24. | Do you have an infant car seat?   | <input type="checkbox"/> Yes                | <input type="checkbox"/> No                 |  |   | 24.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
| 25. | Do you use your car seat belt?  | <input type="checkbox"/> Yes                | <input type="checkbox"/> No                 |  |   | 25.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
| 26. | Was your pregnancy planned?   | <input type="checkbox"/> Yes                | <input type="checkbox"/> No                 |  |   | 26.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
| 27. | How does the baby's father feel about this pregnancy?   | <input type="checkbox"/> doesn't care       | <input type="checkbox"/> doesn't know       | <input type="checkbox"/> angry           | <input type="checkbox"/> happy            | <input type="checkbox"/> sad         | <input type="checkbox"/> other _____   |  |
| 28. | How do you feel about this pregnancy?   | <input type="checkbox"/> don't care         | <input type="checkbox"/> angry              | <input type="checkbox"/> happy           | <input type="checkbox"/> sad              | <input type="checkbox"/> other _____ | 28.  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |
| 29. | Have you ever had any of the following?   | <input type="checkbox"/> miscarriage        | <input type="checkbox"/> abortion           | <input type="checkbox"/> stillbirth      | <input type="checkbox"/> fetal demise     | 29.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
|     | <input type="checkbox"/> neonatal death   | <input type="checkbox"/> premature birth    | <input type="checkbox"/> none               |  |   |                                      |  |  |
|     | When did it happen? _____   |   |   |  |   |                                      |  |  |
|     | What/who helped you get through this? _____   |   |   |  |   |                                      |  |  |
| 30. | Do you have any traditional, cultural, or religious customs about pregnancy or childbirth you would like supported? | <input type="checkbox"/> Yes                | <input type="checkbox"/> No                 |  |   | 30.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
|     | If yes, please explain _____  |   |   |  |   |                                      |  |  |
| 31. | Since becoming pregnant, which of the following have you had? (✓ <input type="checkbox"/> if yes)                   | <input type="checkbox"/> problem sleeping   | <input type="checkbox"/> excessive worrying | <input type="checkbox"/> crying          | <input type="checkbox"/> depression       | 31.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
|     | <input type="checkbox"/> sadness  | <input type="checkbox"/> none               | <input type="checkbox"/> other _____        |  |   |                                      |  |  |
| 32. | Are you taking medicine for your nerves?  | <input type="checkbox"/> Yes                | <input type="checkbox"/> No                 | Name of Medicine _____                   |   | 32.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
| 33. | What two problems in your life cause you the most trouble?  |   |   |  |   | 33.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
|     | 1. _____ 2. _____   |   |   |  |   |                                      |  |  |
| 34. | Have you ever thought about, planned, or tried to hurt yourself?  | <input type="checkbox"/> Yes                | <input type="checkbox"/> No                 |  |   | 34.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
| 35. | Have you ever thought about, planned, or tried to hurt someone else?  | <input type="checkbox"/> Yes                | <input type="checkbox"/> No                 |  |   | 35.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
| 36. | In the past year, have you been slapped, hit, kicked, or otherwise physically hurt by someone?                      | <input type="checkbox"/> Yes                | <input type="checkbox"/> No                 |  |   | 36.                                  | <input type="checkbox"/> L <input type="checkbox"/> M <input type="checkbox"/> H |  |
|     | By whom? (check all that apply)   | <input type="checkbox"/> partner/husband    | <input type="checkbox"/> ex-husband         | <input type="checkbox"/> parent          |   |                                      |  |  |
|     |   | <input type="checkbox"/> step-parent        | <input type="checkbox"/> stranger           | <input type="checkbox"/> brother/sister  |   |                                      |  |  |
|     | <input type="checkbox"/> other _____  | # times hurt _____                          |   |  |   |                                      |  |  |

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37. On this picture



mark the area of the body where you have been hurt.

37. STATUS  
 L  M  H

38. For how many months or years have you been hurt by this person? \_\_\_\_\_  
 Not applicable

38.  L  M  H

39. How many cigarettes do you smoke each day?  
 don't smoke     less than 1/2 pack     1/2 pack     1/2 to 1 pack  
 1-2 packs     2-3 packs     More than 3 packs

39.  L  M  H

40. Do you live with anyone who smokes?     Yes  No

40.  L  M  H

41. Check all that apply:

41.  L  M  H

- a. Does the father of your baby use drugs or drink alcohol?     Yes  No
- Do/did your parents use drugs or drink alcohol?     Yes  No
- Do/did you have friends who use drugs or drink alcohol?     Yes  No

- b. What drugs did you use before this pregnancy?  
 cocaine     marijuana     speed, methamphetamines     PCP  
 heroin     none     other \_\_\_\_\_

- c. How often do you drink beer, wine, or liquor?  
 daily     weekends     1-2 times a month     rarely or never
- Have your alcohol habits changed since you became pregnant?  
 Yes     No    if yes, how? \_\_\_\_\_

42. Have you received counseling on HIV (AIDS) in pregnancy?     Yes  No

42.  L  M  H

43. Tell us what you know about and want to learn about:

43.  L  M  H

Already knows	Like to know	Already know	Like to know
<input type="checkbox"/>	<input type="checkbox"/> Child Care	<input type="checkbox"/>	<input type="checkbox"/> Breastfeeding
<input type="checkbox"/>	<input type="checkbox"/> Hospital Tour	<input type="checkbox"/>	<input type="checkbox"/> Infant Feeding
<input type="checkbox"/>	<input type="checkbox"/> Labor & Delivery	<input type="checkbox"/>	<input type="checkbox"/> Baby Care
<input type="checkbox"/>	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/> Exercise
<input type="checkbox"/>	<input type="checkbox"/> Circumcision	<input type="checkbox"/>	<input type="checkbox"/> Stop Smoking
<input type="checkbox"/>	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/> Domestic Violence
<input type="checkbox"/>	<input type="checkbox"/> How your Baby Grows	<input type="checkbox"/>	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/>	<input type="checkbox"/> Making Children Behave	<input type="checkbox"/>	<input type="checkbox"/> Body Changes During Pregnancy
<input type="checkbox"/>	<input type="checkbox"/> Car Seat Safety	<input type="checkbox"/>	<input type="checkbox"/> Other _____
<input type="checkbox"/>	<input type="checkbox"/> Signs of Preterm Labor	<input type="checkbox"/>	

44. a. How do you learn things best? (please check all that apply)  
 read     watch video     talk-one-to-one  
 go to class     pictures or diagrams     demonstration  
 other \_\_\_\_\_

44.  L  M  H

b. Do you have any problems with hearing, seeing, or depression that will make it hard for you to learn new things?     Yes  No  
If yes, explain? \_\_\_\_\_

45. a. Will you have any problems coming to prenatal classes?     Yes  No  
If yes, explain? \_\_\_\_\_

45.  L  M  H

46. b. Who can come to prenatal classes with you?  
List one or two things (goals) you would like to work on during this pregnancy.  
1. \_\_\_\_\_  
2. \_\_\_\_\_

46.  L  M  H

47. When was the last time that you went to the dentist? \_\_\_\_\_

47. L M H

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**Assessment Tool Completed by:**

Name \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Time spent in minutes: \_\_\_\_\_

**Assessment Reviewed by:**

Name (OB) \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_