Prenatal Plus Program

Intake Form

Name___________________________________Date of Birth______________Medicaid #___________

Congratulations on your pregnancy! We are excited that you are interested in the Prenatal Plus Program for extended health care services for you and your baby. Whether you are a first-time mom or more experienced mom, our mother-centered approach has been proven to help babies grow to full term at a healthy birth weight. As a Prenatal Plus participant, you can access all the program offers during each stage of your pregnancy. This includes affordable health care, individualized care coordination, access to a professional counselor, and registered dietician.

Please answer the questions honestly so we can help ensure a healthy pregnancy for you and your baby.

Nutrition and Exercise

1. During this pregnancy have you had any nausea or vomiting?
   ☐Yes ☐No

2. Do you have any problems that make eating difficult?
   ☐ Yes ☐ No If yes, what?
   ____
   ____

3. How many times do you eat each day?
   ____
   ____

4. Are you on a special diet now such as: low-calorie, low-salt, low-carb, diabetic?
   ☐ Yes ☐ No If yes, why?
   ____
   ____

5. Do you eat or crave non-food items like clay, laundry starch, paint chips, paper, dirt, or ice?
   ☐ Yes ☐ No If yes, what did you crave/eat, how much and how often?
   ____

6. How tall are you? _______ How much did you weigh just before this pregnancy?
   ____

7. If you have been pregnant before, how much weight did you gain with each pregnancy?
   ____
   ____

8. How much weight do you expect to gain during this pregnancy?
   ____

9. Do you exercise?
   ☐Yes ☐ No If yes, what do you do for exercise and how often?
   ____

10. Have you ever run out of food?
    ☐Yes ☐ No

11. Do you feel you have enough food now?
    ☐Yes ☐ No

12. Client's BMI:

    ☐ Low (<19.8) 28-40 # gain
    ☐ Normal (19.8-26.0) 25-35 # gain
    ☐ High (26.1-29.0) 15-25 # gain
    ☐ Obese (>29.0) 15 # gain

Clarify responses here:

13. Have you tried any of the following to lose weight?

☐ used laxatives
☐ made yourself vomit
☐ taken water pills (diuretics)
☐ taken diet pills
☐ not eaten regularly or skipped meals
☐ over exercised

14. Have you ever felt you have lost control over how much you eat?
☐Yes ☐No

15. Have you ever thought or been told you had anorexia or bulimia?
☐Yes ☐No

Sources of Income

1. Are you currently working?
☐Yes ☐No, if yes, what is your job?
____
2. Is the partner of the baby involved?
☐ Yes ☐ No

3. Is the partner of the baby planning to help financially?
☐Yes ☐ No

4. Is your partner currently working?
☐ Yes ☐ No ☐ N/A, if yes, what is your partner's job?
____
5. Do you receive any of the following:
☐ Medicaid
☐ TANF
☐ WIC
☐ SNAP
☐ EPSDT Services
☐ none of the above

Educational /Vocational Goals

1. Are you currently in school?
☐Yes ☐No, if yes, what grade?
____

2. If no, what was the last grade that you finished? ___________

3. If no to question 1, are you interested in finishing school?
☐Yes ☐No

4. Do you have a learning disability?
☐Yes ☐No

5. If yes, do you need help finding resources specific to your learning disability?
☐Yes ☐No

Living Arrangements/transportation

1. What forms of transportation do you use?
____

2. Do you need information on how to use public transportation? (bus/light rail)
☐ Yes ☐ No
3. Where do you live?
☐ apartment, house, mobile home
☐ shelter
☐ no housing
☐ other ___________________________
____

Clarify responses here:

4. Does anyone else live with you in your home?
   ☐ Yes ☐ No, if yes, please provide the following information:

Name	Age	Relationship to you

5. Do you have any other children who do not live with you?
   ☐ Yes ☐ No,
   If yes, where do they live?
   ____

6. How many times have you moved in the past 12 months?
   ____

7. Do you think your current housing situation is adequate and safe?
   ☐ Yes ☐ No

8. Do you need help finding any of the following resources:
   - ☐ Telephone/cell phone
   - ☐ A source to cook food
   - ☐ Refrigerator
   - ☐ Hot water
   - ☐ Heating system
   - ☐ Toilet
   - ☐ Bath/shower

Lifestyle

Please answer the questions honestly so we may help you receive the best possible care for you and your baby.

	Before Pregnancy	**Since getting pregnant**
1. Do you smoke cigarettes? If yes, how many a day?	☐ Yes ☐ No ________________	☐ Yes ☐ No ________________
2. Do you use chewing tobacco?	☐ Yes ☐ No	☐ Yes ☐ No
3. Do you use e-cigarettes?	☐ Yes ☐ No	☐ Yes ☐ No
4. Do you use marijuana?	☐ Yes ☐ No	☐Yes ☐ No

Clarify responses here:

5. Does anyone in your home smoke? Or are you around people who are smoking?
   ☐Yes ☐ No

6. If you are currently smoking or have recently used tobacco, please check the best answer below:
   ☐ I do not want to quit
   ☐ I have thought about quitting but I am not ready yet
   ☐ I want to quit soon
   ☐ I recently quit smoking
   ☐ I quit smoking but I have started again
   ☐ I quit smoking and I will not start again
   ☐ N/A

For the following questions a drink equals one 12-ounce beer, one 4-ounce glass of wine or one 1-ounce shot of hard liquor.

7. When was your last drink?
   ☐ this week ☐ last week ☐ last month ☐ ______ months ago ☐ Never

8. How many drinks does it take for you to feel the effects of alcohol? ______________________

9. Have you ever been treated for problems with alcohol?
   ☐ Yes ☐ No if yes, when? ____

10. Would you like help to quit drinking alcohol while you are pregnant?
    ☐Yes ☐ No

Please answer the questions honestly so we may help you receive the best possible care for you and your baby.

11. Have you used drugs?
    ☐Yes ☐ No if yes, answer the questions below:

12. What types of drugs have you used?	**Before Pregnancy**	**Since getting pregnant**
Meth/speed	☐ Yes ☐ No	☐ Yes ☐ No
Cocaine/crack	☐ Yes ☐ No	☐ Yes ☐ No
Heroin	☐ Yes ☐ No	☐ Yes ☐ No
Ecstasy	☐ Yes ☐ No	☐ Yes ☐ No
PCP or LSD	☐ Yes ☐ No	☐ Yes ☐ No
Sniffed gasoline, glue or other substance	☐ Yes ☐ No	☐ Yes ☐ No
Use needles for drugs	☐ Yes ☐ No	☐ Yes ☐ No
Other	☐ Yes ☐ No	☐ Yes ☐ No

13. Have you ever been addicted to painkillers such as Percocet, Vicodin or OxyContin?
    ☐ Yes ☐ No

Clarify responses here:

14. When was the last time you used drugs?
☐ this week ☐ last week ☐ last month ☐ ______ months ago ☐ Never

15. Have you ever been treated for problems with drugs?
☐Yes ☐ No if yes, when? ____

16. Would you like help to quit using drugs (including marijuana) while you are pregnant?
☐Yes ☐ No

17. Does anyone in your home have a problem with drugs or alcohol?
☐Yes ☐ No

Education and Resources

The Prenatal Plus Program has helpful information for you during your pregnancy. Please check any topics you would like more information about:

- ☐ breastfeeding and other infant feeding options
- ☐ finding a doctor for yourself and family
- ☐ nutrition
- ☐ exercise
- ☐ assistance getting food
- ☐ work options
- ☐ resources for clothing, baby furniture, etc.
- ☐ financial help
- ☐ school
- ☐ housing shelter
- ☐ counseling
- ☐ getting along with your partner or family
- ☐ how to prevent a low birthweight or premature baby
- ☐ caring for yourself and your baby after you get home
- ☐ other____
- ☐ postpartum depression or anxiety
- ☐ quitting smoking
- ☐ secondhand smoke
- ☐ quitting drugs or alcohol
- ☐ coping with changes during pregnancy
- ☐ growth and development of your baby
- ☐ parenting
- ☐ childbirth classes
- ☐ labor and delivery
- ☐ birth control methods
- ☐ day care

I agree to participate in the ____ Prenatal Plus Program.
(Name of Agency)

Member Signature: ____Date completed: __________________

Care Coordinator Signature: _________________________________Date Reviewed: ___________________