CYFD Home Visiting Program

Maternal-Child Health/Demographic Information Form

This information about you and your family will help your home visitor work with you to figure out supports and services you may want. For reporting to funders, your information will never be identified by name but will be used as group data only.

Mother’s Name: ___________________________ DOB: ____________
Father/Partner’s Name: ________________________ DOB: ____________

If enrolled in program

Intake __________ Update #1__________ Update #2__________ Update #3___________
_________________ __________ date __________ date __________ date

Part 1: Maternal Health Information

1. Health care visits: Have you attended one or more doctor or clinic appointments during the past 12 months for regular health care? ____Y ____N

2. Are you currently pregnant? _____Y _____N

3. Do you use any method of family planning/birth control? ____Y ____N

4. Have you been in a hospital emergency room/urgent care center in the past 12 months?
   # of times ____None ____x1 ____x2 ____x3 or more

5. If “Yes” (Mother in emergency room/urgent care center), check applicable reasons:
   a. _____Illness
   b. _____Injury from accident
   c. _____Dental problems
   d. _____Injury from domestic violence
   e. _____Routine or follow-up care

6. Describe how often you drink alcohol
   a. _____Do not drink alcohol
   b. _____Less than one drink per day
   c. _____One drink per day
   d. _____More than one drink per day

7. Describe how you use tobacco products
   a. _____Do not use tobacco in any form including chewing tobacco
   b. _____Less than one pack or chewing tin per week
   c. _____One pack or chewing tin per day
   d. _____Two or more packs/chewing tins per day
8. Do any family members (including you) use tobacco products in the home? _____Y _____N

9. Describe how you use recreational/illegal drugs (such as marijuana, cocaine, opiates, inhalants, etc)
   a. _____Do not use drugs in any form
   b. _____Less than daily
   c. _____Daily one or more times

**Part 2: Family Demographic Information**

<table>
<thead>
<tr>
<th>Mother</th>
<th>Father/Partner (enrolled)</th>
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</thead>
<tbody>
<tr>
<td>1. Health insurance (check all that apply)</td>
<td>5. Health insurance (check all that apply)</td>
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<tr>
<td>a. _____No insurance</td>
<td>a. _____No insurance</td>
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<td>b. _____Private insurance</td>
<td>b. _____Private insurance</td>
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<tr>
<td>c. _____Medicaid</td>
<td>c. _____Medicaid</td>
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<tr>
<td>d. _____Use Indian Health Services</td>
<td>d. _____Use Indian Health Services</td>
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<td>e. _____Tricare (military)</td>
<td>e. _____Tricare (military)</td>
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<tr>
<td>2. Educational status:</td>
<td>6. Educational status:</td>
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<tr>
<td>a. _____Currently enrolled in High School</td>
<td>a. _____Currently enrolled in High School</td>
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<tr>
<td>b. _____High School eligible, not enrolled</td>
<td>b. _____High School eligible, not enrolled</td>
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<tr>
<td>c. _____Less than High School diploma (beyond HS eligibility age)</td>
<td>c. _____Less than High School diploma (beyond HS eligibility age)</td>
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<td>d. _____High School diploma</td>
<td>d. _____High School diploma</td>
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<tr>
<td>e. _____GED</td>
<td>e. _____GED</td>
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<tr>
<td>f. _____Some college/technical training</td>
<td>f. _____Some college/technical training</td>
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<td>g. _____Technical training certificate or Associate degree</td>
<td>g. _____Technical training certificate or Associate degree</td>
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<td>h. _____Bachelor’s degree or higher</td>
<td>h. _____Bachelor’s degree or higher</td>
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<tr>
<td>i. _____Other __________________</td>
<td>i. _____Other __________________</td>
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<tr>
<td>a. _____Student/Trainee</td>
<td>a. _____Student/Trainee</td>
</tr>
<tr>
<td>b. _____Not a Student/Trainee</td>
<td>b. _____Not a Student/Trainee</td>
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<tr>
<td>4. Employment:</td>
<td>8. Employment:</td>
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<tr>
<td>a. _____Not employed</td>
<td>a. _____Not employed</td>
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<td>b. _____Employed part-time</td>
<td>b. _____Employed part-time</td>
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<tr>
<td>c. _____Employed full-time</td>
<td>c. _____Employed full-time</td>
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</tbody>
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9. Please check benefits received by your immediate family:
   _____WIC _____Food Stamps _____TANF _____Disability ___ SSI ___Unemployment ____Head Start
10. Estimated annual family income from all sources: $____________________

11. Family size: _____1 _____2 _____3 _____4 _____5 _____6 _____7 or more

12. Are any members of your immediate family currently serving or have they formerly served in the Armed Forces? _____Y _____N
Part 3: Child Health Information

Please complete a copy of this form for each of your children enrolled in the home visiting program.

Child’s Name: _______________________________________  DOB: _________________

Intake _______ Update #1__________  Update #2__________  Update #3___________
   date          date          date          date

1. Well-child visits: Has your child attended one or more appointments during the past 12 months for a “well-child” regular check-up? ____Y ____N

2. Name of pediatrician and/or clinic: __________________________________________

3. Immunizations: Has your child had all recommended shots? ____Y ____N

4. Has your child been in a hospital emergency room/urgent care center in the past 12 months?  # of times: ____None ____x1 ____x2 ____x3 or more

5. If “Yes” (child in emergency room/urgent care center), check applicable reasons:
   a. _____Illness
   b. _____Injury from accident
   c. _____Dental problems
   d. _____Reported child abuse or neglect
   e. _____Routine or follow-up care

6. Child’s health insurance (check all that apply)
   a. _____No insurance
   b. _____Private insurance
   c. _____Medicaid
   d. _____New Mexikids (S-CHIP)
   e. _____Uses Indian Health Services

Thank you for completing these questions for the CYFD Home Visiting program. Please let your home visitor know about questions and problems you may have.