CPSP Integrated Initial and Trimester Assessments and Individualized Care Plan

Client Orientation:
- Client orientation per protocol
- States understands Welcome to Pregnancy Care
- States understands CPSP is voluntary and agrees to participate
- Reviewed STT HE, Pregnant? Steps for a Healthy Baby
- Vitamins per protocol

Minutes:________ Signature:________

Date of Orientation:________

Document additional Orientation in Progress Note

Client Identifier

DOB:________ Age:________

EDD:________ Weeks Gestation________

OB problem list reviewed, if available, before conducting assessments.

1st TM 2nd TM 3rd TM

Assessment: Complete all items regardless of which trimester client begins care

Psychosocial:

<table>
<thead>
<tr>
<th>Psychosocial Needs/Risks/Concerns (ask questions in Initial, 2nd or 3rd trimester as indicated)</th>
<th>Psychosocial Individualized Care Plan Developed with Client</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is this a planned pregnancy? ☑Yes ☐No, describe:</td>
<td>☑Client states she understands STT PSY, ☑Uncertain about Pregnancy, ☑Choices</td>
<td></td>
</tr>
<tr>
<td>2. Is this a wanted pregnancy? ☑Yes ☐No, describe:</td>
<td>☑Client goal/plan:</td>
<td></td>
</tr>
<tr>
<td>3. Are you considering abortion/ adoption? ☐No ☑Yes, describe:</td>
<td>☑Client wishes more support, identified sources:</td>
<td></td>
</tr>
<tr>
<td>4. How does the FOB/Partner feel about the pregnancy? ☑Happy ☑Involved ☑Upset ☐FOB/Partner not sure ☐Uninvolved ☐FOB/Partner doesn’t know ☐Client doesn’t know how partner feels</td>
<td>☑Referred to/for:</td>
<td></td>
</tr>
<tr>
<td>5. What are your goals for this pregnancy?: ☑healthy baby ☐other:</td>
<td>☑Client goal/plan:</td>
<td></td>
</tr>
<tr>
<td>6. Have you had issues with previous pregnancies? ☐N/A ☑No ☑Yes, describe:</td>
<td>☑Client goal/plan:</td>
<td></td>
</tr>
<tr>
<td>☑Would you like information on how to reduce risk in this pregnancy? ☑Yes ☐No</td>
<td>☑Consult with OB provider</td>
<td></td>
</tr>
<tr>
<td>7. Have you had a previous pregnancy loss/ infant death? ☐No ☑Yes, describe:</td>
<td>☑Client goal/plan:</td>
<td></td>
</tr>
<tr>
<td>☑Client states aware of support resources</td>
<td>☑Referred to/for:</td>
<td></td>
</tr>
<tr>
<td>8. Members of household (not including client)</td>
<td>☑Client goal/plan:</td>
<td></td>
</tr>
<tr>
<td>Number of adults:________ Relationship to client:</td>
<td>☑Referred to/for</td>
<td></td>
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<tr>
<td>Number of children:________ Relationship to client:</td>
<td></td>
<td></td>
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<tr>
<td>9. Do all of your children live with you? ☐N/A ☑Yes ☐No, describe:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Are you currently receiving services from a local agency such as case management, home visiting, counseling etc.? ☐No ☑Yes, describe:</td>
<td>☑Client goal/plan:</td>
<td></td>
</tr>
<tr>
<td>☑Obtained client’s written permission to share information with:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency:_________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact person:___________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone:________________ Fax:_______________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial Needs/Risks/Concerns (ask questions in Initial, 2nd or 3rd trimester as indicated)</td>
<td>Psychosocial Individualized Care Plan Developed with Client</td>
<td>Comment</td>
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<td>---</td>
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<tr>
<td></td>
<td>Client goal/plan:</td>
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<td>Client goal/plan:</td>
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<td>Client goal/plan:</td>
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<tr>
<td></td>
<td>Client goal/plan:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>States understands STT PSY Cycle of Violence</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Made safety goal/plan</td>
<td></td>
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<tr>
<td></td>
<td>Client states understands legal options</td>
<td></td>
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<tr>
<td></td>
<td>Agrees to follow STT PSY: Safety When Preparing to Leave</td>
<td></td>
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<tr>
<td></td>
<td>Referred to/for:</td>
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<tr>
<td></td>
<td>If minor, completed mandated report, date:________</td>
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<tr>
<td></td>
<td>If current injuries/adult, reported to OB provider</td>
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<tr>
<td></td>
<td>Reported to law enforcement, date:_________</td>
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<td></td>
<td>In contact with law enforcement/agency already:</td>
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<td></td>
<td>Client goal/plan:</td>
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<td>states understands:</td>
<td></td>
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<td></td>
<td>STT PSY Cycle of Violence</td>
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<tr>
<td></td>
<td>What to do in an emergency</td>
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<tr>
<td></td>
<td>Legal options.</td>
<td></td>
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<tr>
<td></td>
<td>Agrees to follow STT PSY: Safety When Preparing to Leave</td>
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<tr>
<td></td>
<td>Made safety plan</td>
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<td>Referred to/for:</td>
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<td>Client identified possible sources of support</td>
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<td>Client goal/plan:</td>
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<td>Referred to/for:</td>
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<td>Update:</td>
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</tbody>
</table>

11. Have you ever seen a counselor for personal or family issues or support?  

- No  
- Yes, describe:  

Do you need counseling now?  

- No  
- Yes, describe:  

12. Have you ever been emotionally, physically, or sexually abused by a partner or someone close to you?  

- No  
- Yes, describe:  

Do you have injuries now?  

- No  
- Yes, describe:  

Do you feel in danger now?  

- No  
- Yes, describe:  

13. Within the last year, have you ever been hit, slapped, kicked, pushed, shoved, forced to have sex, forced to get pregnant or otherwise physically hurt by your partner or ex-partner?  

- No  
- Yes, by whom?  

Do you have injuries now?  

- No  
- Yes, describe:  

14. Are you afraid of your partner or ex-partner?  

- No  
- Yes, describe:  

15. Are you having any other personal or family challenges?  

- No  
- Yes, describe:  

16. Who do you turn to for emotional support?  

- FOB/partner  
- Family member:  
- Friend:  
- Other:  

- No one, describe:  

- No one, describe:  

- No one, describe:  

CPSP Initial and Trimester sample combined assessment and care plan 5/2014
### Psychosocial Needs/Risks/Concerns (ask questions in Initial, 2nd or 3rd trimester as indicated)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No Options</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Do you often feel down, sad or hopeless?</td>
<td>Yes, describe</td>
<td>Have you lost interest or pleasure in doing things that you used to enjoy?</td>
</tr>
<tr>
<td>18. Did your parents use alcohol or drugs?</td>
<td></td>
<td>Client states understands risks</td>
</tr>
<tr>
<td>19. Does your partner use alcohol or drugs?</td>
<td></td>
<td>Client states understands risks</td>
</tr>
<tr>
<td>20. Before you knew you were pregnant, how much beer/wine/liquor did you</td>
<td></td>
<td>Client states understands risks</td>
</tr>
<tr>
<td>21. Before you knew you were pregnant, how much tobacco did you smoke</td>
<td></td>
<td>Client states understands risks</td>
</tr>
</tbody>
</table>

### Psychosocial Individualized Care Plan Developed with Client

| Screen for signs of emotional concerns at future appointments           |
| Referred to provider or psychosocial consultant for assessment and intervention |
| Client goal/plan:                                                      |

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### Update:

- **Ask the above questions, describe response:**
- **Ask the above questions, describe response:**
- **Ask the above questions, describe response:**
- **Ask the above questions, describe response:**

---

### Client Identifier

- CPSP Initial and Trimester sample combined assessment and care plan 5/2014
## Psychosocial Needs/Risks/Concerns
(ask questions in Initial, 2nd or 3rd trimester as indicated)

### Client Identifier

<table>
<thead>
<tr>
<th>Psychosocial Individualized Care Plan Developed with Client</th>
<th>Comment</th>
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</thead>
<tbody>
<tr>
<td>Yes, states understands STT HE: <strong>You can Quit Smoking</strong></td>
<td></td>
</tr>
<tr>
<td>Referred to CA Smokers’ Helpline 1-800-NoButts</td>
<td></td>
</tr>
<tr>
<td>Consult with OB provider</td>
<td></td>
</tr>
<tr>
<td>Referred to/for:</td>
<td></td>
</tr>
</tbody>
</table>

### Psychosocial Individualized Care Plan

#### Client’s Goal/Plan:

- **Smoking**
  - About the same amount

- **Are you smoking now?**
  - Yes **No**
  - Stopped smoking and is not smoking now
  - Cut down to
  - Smoking about the same amount

#### Client’s Goal/Plan:

- **States**
  - Understands STT HE: You can Quit Smoking
  - Has decided to: cut down to how much ________
  - not to use any drugs
  - Client’s confidence in quitting (circle): 1 2 3 4 5 6 7 8 9 10
  - Support person: Consult with OB provider
  - Referred to/for: Obtained client’s written permission to exchange information with:
    - Agency:
    - Contact person: __________________________
    - Phone: __________________________ Fax: __________________________

#### Client’s Goal/Plan:

- **Do people smoke around you?**
  - Yes, about ________ hours per day
  - No, about ________ hours per day
  - No, about ________ hours per day

#### Client’s Goal/Plan:

- **Before you knew you were pregnant, how much did you usually use marijuana or other drugs?**
  - None
  - Was using: ________ ________ a day/wk/month
  - amount drug
  - Are you using drugs now? No
  - Yes, now using: ________ ________ a day/wk/month
    - amount drug
  - Update:

#### Client’s Goal/Plan:

- **What is your source of financial support?**
  - Self, type of work:
  - FOB/partner, type of work:
  - Family member/ friend:
  - CalWORKS
  - SSI
  - Other: Referred to/for:

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CPSP Initial and Trimester sample combined assessment and care plan 5/2014
### Psychosocial Needs/Risks/Concerns (ask questions in Initial, 2nd or 3rd trimester as indicated)

<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Update</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Where do you live?</td>
<td>□ Apartment/house □ other: ____________</td>
<td>□ Concerns, describe:</td>
<td>Update:</td>
</tr>
<tr>
<td>26. Any other questions or concerns?</td>
<td>□ None □ Yes, describe:</td>
<td>□ Concerns/changes, describe:</td>
<td>Update:</td>
</tr>
<tr>
<td>27. Discussed results of assessment with client and client identified the following strengths:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Psychosocial

1. Minutes spent ____________ Completed by: ____________________________
   Signature ____________ Title ____________ Date ____________

Signature of medical provider if assessor is CPHW: ____________________________
   Signature ____________ Title ____________ Date ____________

2. Minutes spent ____________ Completed by: ____________________________
   Signature ____________ Title ____________ Date ____________

3. Minutes spent ____________ Completed by ____________________________
   Signature ____________ Title ____________ Date ____________
# Health Education

## Health Education Learning Needs/Risks/Concerns (ask questions in Initial, 2nd or 3rd trimester as indicated in each cell)

<table>
<thead>
<tr>
<th>Question</th>
<th>Health Education Individualized Care Plan Developed with Client</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How do you like to learn?: □ Text message reminders □ Classes/groups □ Videos □ Individual teaching □ Read aloud □ Other:</td>
<td>□ Will use following learning methods: □ Client wishes adapted education methods, such as using pictures or low literacy materials</td>
<td></td>
</tr>
<tr>
<td>How well do you write/read? □ good/fair □ poor/non-reader</td>
<td>□ Will sign up for Text4Baby</td>
<td></td>
</tr>
<tr>
<td>2. Do you have someone you can talk to about what we discussed today? □ Yes, identify __________________________ □ No</td>
<td>□ Client stated she will involve a support person by sharing educational materials after her appointments</td>
<td></td>
</tr>
<tr>
<td>In what language would you like materials?______________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. What was the last grade you completed?________________________________</td>
<td>□ Referred to:</td>
<td></td>
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<tr>
<td>□ Less than high school/GED</td>
<td></td>
<td></td>
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<tr>
<td>5. How long have you lived in this area? □ More than a year □ Less than one year Do you plan to stay in this area for the rest of your pregnancy? □ Yes □ No, comments:</td>
<td>□ Client verbalizes understanding of available health care services □ Provide a copy of her medical records if she needs to leave the area □ Referred to:</td>
<td></td>
</tr>
<tr>
<td>Do you know how to get other health care services? □ Yes □ No, comments:</td>
<td>□ Referred to:</td>
<td></td>
</tr>
<tr>
<td>6. Do you have any physical difficulties that affect learning? (Such as vision, hearing, learning disabilities)? □ No □ Yes, describe:</td>
<td>□ Client wishes adapted health education methods □ Consult with OB provider □ Referred to/for:</td>
<td></td>
</tr>
<tr>
<td>7. Who gives you advice about your pregnancy? □ No one □ Mother □ Mother-in-law □ Grandmother □ Partner □ Sister □ Friend □ Other:</td>
<td>□ Referred to support group: _____________________________________ □ Client stated she will consult with OB provider regarding the following possibly harmful advice:</td>
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</tr>
<tr>
<td>What are the most important things they have told you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Are you exposed to any of the following at work or home? □ Chemicals, fumes, pesticides, lead □ Cats □ Rodents □ Douching □ Hot baths □ X-rays □ Other □ No, none of the above</td>
<td>□ Client goal/plan: □ Follow STT HE Pregnant? Steps for a Healthy Baby □ Keep Safe at Work □ Consult with OB provider re:</td>
<td></td>
</tr>
<tr>
<td>□ Client has MotherToBaby California information (866) 626-6847 <a href="http://www.mothertobabyca.org">www.mothertobabyca.org</a> □ Mailed or faxed MotherToBaby client referral form</td>
<td>□ Client stated she will involve a support person by sharing educational materials after her appointments</td>
<td></td>
</tr>
<tr>
<td>9. We ask all clients this question: do you have any of these risk factors for diseases like chlamydia, gonorrhea, herpes, or HIV? □ More than one sexual partner? □ Ever had sex while using alcohol or drugs? □ Have you or any partners ever had an STD? □ Has your partner had sex with anybody else? □ Have you or any partners exchanged sex for drugs, money, or shelter? □ Have you or any partners ever injected drugs not prescribed by a doctor?</td>
<td>□ Client agrees to follow STT HE □ What you Should Know about STDs □ What you should Know about HIV □ You Can Protect Yourself and Your Baby from HIV □ Referred to:</td>
<td></td>
</tr>
<tr>
<td>10. Which of the following topics would you like to learn about? □ Body changes during pregnancy □ Baby’s growth, □ Immunizations for pregnant women (flu, Tdap) □ Other topics, describe: ______________</td>
<td>□ Reviewed the following items with client: □ Client will discuss the following with OB provider:</td>
<td></td>
</tr>
<tr>
<td>□ None, follow up at next visit</td>
<td>□ Reviewed the following items with client:</td>
<td></td>
</tr>
</tbody>
</table>
### Health Education Learning Needs/Risks/Concerns

<table>
<thead>
<tr>
<th>Client Identifier</th>
<th>Health Education Individualized Care Plan Developed with Client</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is your peak weight?</td>
<td>Welcome to Pregnancy Care</td>
<td></td>
</tr>
<tr>
<td>2. Have you had a dental check-up in the past 12 months?</td>
<td>Client Goal/plan: Follow STT HE Prevent Gum Problems</td>
<td></td>
</tr>
<tr>
<td>3. Have you always used a seat belt?</td>
<td>Client goal/plan:</td>
<td></td>
</tr>
<tr>
<td>4. Can you describe what you think might be pregnancy danger signs, symptoms of preterm labor, labor induction, and when to call the doctor for prenatal concerns?</td>
<td>Client goal/plan:</td>
<td></td>
</tr>
<tr>
<td>5. Discussed above items:</td>
<td></td>
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<tr>
<td>6. Discussed above items:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. What are your plans for labor and delivery?</td>
<td>Client referred to hospital tour: Name of hospital:</td>
<td></td>
</tr>
<tr>
<td>8. Do you have any questions about how to take care of yourself?</td>
<td>Client referred to childbirth preparation class</td>
<td></td>
</tr>
</tbody>
</table>

**CPSP Initial and Trimester sample combined assessment and care plan 5/2014**
### Health Education Learning Needs/Risks/Concerns (ask questions in Initial, 2nd or 3rd trimester as indicated in each cell)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>after delivery?</td>
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<tr>
<td>- Discussed importance of postpartum care, procedure for making appointments.</td>
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<tr>
<td>17. Do you know about infant: care, safety, illness, safe sleep, immunizations?</td>
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<tr>
<td>18. Do you have the following items? baby supplies/clothing/safe sleeping</td>
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<tr>
<td>- Child passenger safety seat</td>
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<td></td>
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<tr>
<td>- Child care, if returning to work or school</td>
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<tr>
<td>Needs:</td>
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<tr>
<td>19. Have you chosen a doctor for the baby?</td>
<td>Yes</td>
<td>No</td>
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<td>- Name of provider</td>
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<td></td>
</tr>
<tr>
<td>20. Do you plan to have more children?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>- How many?</td>
<td></td>
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<tr>
<td>21. Do you have a doctor you can go to for regular medical checkups?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>- Name:</td>
<td></td>
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<tr>
<td>22. Do you have health insurance for care after your pregnancy?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>23. Has your doctor told you that you have any health problems that need follow up after your pregnancy? (diabetes, high blood pressure, obesity, depression etc.)</td>
<td>No</td>
<td>Yes, describe:</td>
</tr>
<tr>
<td>24. Do you have any other questions or concerns?</td>
<td>No</td>
<td>Yes, describe:</td>
</tr>
<tr>
<td>25. Reviewed health education assessment with client and client identified the following strengths:</td>
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<tr>
<td>Health Education Learning Needs/Risks/Concerns (ask questions in Initial, 2nd or 3rd trimester as indicated in each cell)</td>
<td>Health Education Individualized Care Plan Developed with Client</td>
<td>Comment</td>
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**Health Education:**

1. Minutes spent ____________ Completed by: ___________________________  
   Signature ___________________________________  
   Title __________________  
   Date ________________  

Signature of medical provider if assessor is CPHW: ___________________________  
Signature ___________________________________  
Title __________________  
Date ________________  

2. Minutes spent ____________ Completed by: ___________________________  
   Signature ___________________________________  
   Title __________________  
   Date ________________  

3. Minutes spent ____________ Completed by: ___________________________  
   Signature ___________________________________  
   Title __________________  
   Date ________________
### Nutrition

#### Anthropometric: Height, Weight, & Body Mass Index (BMI)

1. **Pre-pregnancy weight:** _____ lbs. **Height** _____ **BMI** _____
   - **BMI category/Weight Gain Grid used:**
     - [ ] Underweight  [ ] Normal  [ ] Overweight  [ ] Obese
   - **Currently pregnant with multiples?**
     - [ ] Twins  [ ] Triplets or more (consult w/ provider for wt. gain goal)
   - **During previous pregnancy how much weight did you gain?**
     - _____ lbs.  [ ] N/A

2. **Current weight gain:** _____ lbs
   - [ ] Appropriate  [ ] Excessive  [ ] Inadequate
   - **How do you feel about the weight you have gained so far with this pregnancy?**
     - **What questions do you have about your weight gain during pregnancy?**

3. **Current weight gain:** _____ lbs
   - [ ] Appropriate  [ ] Excessive  [ ] Inadequate
   - **How do you feel about the weight you have gained so far with this pregnancy?**

#### Biochemical: Lab Values

- **3.** Consult with provider regarding whether there are abnormal lab values and treatment prescribed.
  - **HGB** _____  **HCT** _____
  - **Fasting Blood Glucose**
  - **Date of consultation with provider:**
  - **Abnormal lab values:**  [ ] No  [ ] Yes, Explain:

- **2.** Consult with provider regarding whether there are abnormal lab values and treatment prescribed.
  - **Fasting Blood Glucose**
  - **Date of consultation with provider:**
  - **Abnormal lab values:**  [ ] No  [ ] Yes, Explain:

- **3.** Consult with provider regarding whether there are abnormal lab values and treatment prescribed.
  - **Fasting Blood Glucose**
  - **Date of consultation with provider:**
  - **Abnormal lab values:**  [ ] No  [ ] Yes, Explain:
### Nutrition Assessment (ask questions in Initial, 2nd or 3rd trimester as indicated)

<table>
<thead>
<tr>
<th>Clinical</th>
<th></th>
<th>Nutrition Individualized Care Goal/plan Developed with Client</th>
<th>Comment</th>
</tr>
</thead>
</table>

4. **Blood Pressure**

- Blood Pressure
- Blood Pressure
- Blood Pressure

- Provider notified if BP > 120/80
- Provider notified if BP > 120/80
- Provider notified if BP > 120/80

5. **Do you have any of the following possibly nutrition-related discomforts?**

- Nausea
- Vomiting
- Leg cramps
- Gas
- Heartburn
- Constipation
- Hemorrhoids
- Swelling of feet or hands
- Dizziness
- Diarrhea
- Other:

- Discuss symptoms with provider Date____

- Client agrees to follow STT N handout(s) (indicate date):
- **Nausea: Tips that Help**
- **Nausea: What To Do When You Vomit**
- **Nausea: Choose these Foods**
- **Heartburn: What You Can Do**
- **Heartburn: Should You Use**
- **Constipation: What You Can Do**
- **Constipation: Products You Can Use and Cannot Use**

- Do you have trouble with milk foods?____

- Client reviewed WIC handout: Feeling Comfortable While Pregnant
  - www.cdph.ca.gov/programs/wicworks/Pages/WICEducationMaterialsWomen.aspx

- Referred to RD (date):________

- Discussed symptoms with provider
- Referred to RD (date):________
- Referred to (profession and date):________
- Client will:________
### Nutrition Assessment
(ask questions in Initial, 2nd or 3rd trimester as indicated)

6. Do you have any of these nutrition-related health issues?
   - Under 19 years of age
   - This pregnancy began less than 24 months since a prior birth
   - Currently breastfeeding another child
   - Gastric Surgery
   - Diabetes  □ Type 1  □ Type 2  □ Gestational
   - Ever had a baby who weighed less than 5 1/2 pounds
   - Ever had a baby who weighed more than 9 pounds
   - Ever been told any of your unborn babies were not growing well
   - Ever had an eating disorder, such as anorexia, bulimia, disordered eating
   - Other current or previous nutrition related health issues. Explain:

   Are there any new nutrition-related health issues?
   - No  □ Yes. Explain:

   Are there any new nutrition-related health issues?
   - No  □ Yes. Explain:

### Dietary

7. Are you currently taking any of the following?

<table>
<thead>
<tr>
<th></th>
<th>Which one?</th>
<th>How much /often?</th>
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<tbody>
<tr>
<td>Iron</td>
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<tr>
<td>Folic Acid</td>
<td></td>
<td></td>
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<tr>
<td>Prenatal vitamins/minerals</td>
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<tr>
<td>Other vitamins or mineral</td>
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<tr>
<td>Home remedies or herbs/teas</td>
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<tr>
<td>Liquid or powdered supplements</td>
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<tr>
<td>Laxatives</td>
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<tr>
<td>Prescription medicines</td>
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<tr>
<td>Antacids</td>
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<tr>
<td>Over-the-counter medicines</td>
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</table>

Are there any changes to supplements/medications noted above?
   - No  □ Yes. Explain:

Are there any changes to supplements/medications noted above?
   - No  □ Yes. Explain:

---

**Comment**

- Discussed risks with provider Date:
- Client agrees to follow STT N handout(s) (indicate date):
- **MyPlate for Gestational Diabetes**
- If You Have Diabetes While You Are Pregnant: Questions You May Have
- If You Have Diabetes While You Are Pregnant: Relax and Lower Your Stress
- Referred to RD (date):
- Referred to (profession and date):
- Client will:

- Discussed findings with provider, date:
- Client agrees to follow STT N handout(s) (indicate date):
- Take Prenatal Vitamins and Minerals
- Get the Folic Acid You Need
- Get The Iron You Need
- If You Need Iron Pills
- Iron Tips
- Iron Tips: Take Two
- My Action Plan for Iron
- Get the Folic Acid You Need
- Vitamin B12 is Important
- Foods Rich in Calcium
- You May Need Extra Calcium
- Constipation: What You Can Do
- Referred to RD (date):
- Referred to (profession and date):
- Client will take prenatal vitamins
- Client will:

- Discussed all new findings with provider Date:
- Referred to RD (date):
- Referred to (profession and date):
- Client will take prenatal vitamins
- Client will:

- Update:
<table>
<thead>
<tr>
<th>Client Identifier</th>
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</table>

### Nutrition Assessment (ask questions in Initial, 2nd or 3rd trimester as indicated)

8. Have you had any changes in your appetite or eating habits since becoming pregnant?
   - [ ] No  [ ] Yes. Explain:

8. Have you had any changes in your appetite or eating habits?
   - [ ] No  [ ] Yes. Explain:

8. Have you had any changes in your appetite or eating habits?
   - [ ] No  [ ] Yes. Explain:

9. Do you limit or avoid any food or food groups (such as meat or dairy)?
   - [ ] No  [ ] Yes. Explain:
     - Why do you avoid these foods?
       - [ ] Do not like  [ ] Allergy  [ ] Physician advice
       - [ ] Intolerance  [ ] Personal Choice
       - [ ] Other: __________________________

   - Are there any changes to food groups avoided?
     - [ ] No  [ ] Yes. Explain:

   - Are there any changes to food groups avoided?
     - [ ] No  [ ] Yes. Explain:

10. Have you fasted during this pregnancy or do you plan to fast?
    - [ ] No  [ ] Yes. Explain how long and how often:

11. Do you ever eat any of the following:
    - [ ] Raw or undercooked eggs, meat, shellfish, fish, including sushi
      - [ ] Alfalfa/mung bean sprouts
      - [ ] Deli meat or hot dogs without heating or steaming
      - [ ] Unpasteurized milk, cheese or juice, including soft cheeses such as feta, blue cheese, queso de crema, asadero, queso fresco, panela, or homemade
      - [ ] Shark, swordfish, king mackerel, or tilefish
      - [ ] Albacore tuna >6 ounces/week  [ ] Fish more than 2x/week
      - [ ] Locally caught fish more than 1x/week

    - Are there any changes to food choices noted above?
      - [ ] No  [ ] Yes. Explain:

    - Are there any changes to food choices noted above?
      - [ ] No  [ ] Yes. Explain:

### Nutrition Individualized Care Goal/plan Developed with Client

- Client agrees to follow STT N handout(s) (indicate date):
  - [ ] Do You Have Trouble with Milk Foods
  - [ ] Foods Rich in Calcium
  - [ ] You May Need Extra Calcium
  - [ ] Vitamin B12 is Important
  - [ ] Get the Folic Acid You Need
  - [ ] If You Need Iron Pills
  - [ ] Iron Tips: Take Two
  - [ ] Iron Tips: Take Two
  - [ ] My Action Plan for Iron
  - [ ] When You Are a Vegetarian: What Do You Need To Know

- Client agrees to follow STT N handout(s) (indicate date):
  - [ ] Choose Healthy Foods
  - [ ] MyPlate for Moms/My Nutrition Plan for Moms
  - [ ] MyPlate for Gestational Diabetes

- Client agrees to follow STT N handout(s) (indicate date):
  - [ ] Don’t Get Sick From the Foods you Eat
  - [ ] Lower Your Chances of Eating Food with Unsafe Chemicals in Them
  - [ ] Checklist for Food Safety
  - [ ] Tips for Cooking and Storing Food
  - [ ] Tips for Keeping Foods Safe
  - [ ] Eat Fish Safely

- Client agrees to follow STT N handout(s) (indicate date):
  - [ ] Referred to RD (date): __________________
  - [ ] Referred to (profession and date): __________________
  - [ ] Client will: ____________________________

- Client agrees to follow STT N handout(s) (indicate date):
  - [ ] Referred to RD (date): __________________
  - [ ] Referred to (profession and date): __________________
  - [ ] Client will: ____________________________

- Client agrees to follow STT N handout(s) (indicate date):
  - [ ] Referred to RD (date): __________________
  - [ ] Referred to (profession and date): __________________
  - [ ] Client will: ____________________________

- Client agrees to follow STT N handout(s) (indicate date):
  - [ ] Referred to RD (date): __________________
  - [ ] Referred to (profession and date): __________________
  - [ ] Client will: ____________________________

- Client agrees to follow STT N handout(s) (indicate date):
  - [ ] Referred to RD (date): __________________
  - [ ] Referred to (profession and date): __________________
  - [ ] Client will: ____________________________

- Client agrees to follow STT N handout(s) (indicate date):
  - [ ] Referred to RD (date): __________________
  - [ ] Referred to (profession and date): __________________
  - [ ] Client will: ____________________________

- Client agrees to follow STT N handout(s) (indicate date):
  - [ ] Referred to RD (date): __________________
  - [ ] Referred to (profession and date): __________________
  - [ ] Client will: ____________________________

- Client agrees to follow STT N handout(s) (indicate date):
  - [ ] Referred to RD (date): __________________
  - [ ] Referred to (profession and date): __________________
  - [ ] Client will: ____________________________
**Nutrition Assessment** (ask questions in Initial, 2nd or 3rd trimester as indicated)

12. Do you eat or have you craved any of the following? 
- [ ] Clay or dirt
- [ ] Laundry starch
- [ ] Cornstarch
- [ ] Ice or freezer frost
- [ ] Plaster or paint chips
- [ ] Other non-food item: ________________________

Are there any changes to non-food cravings noted above? 
- [ ] No [ ] Yes. Explain: ________________________

13. Do you have the following? 
- [ ] Oven
- [ ] Electricity
- [ ] Microwave
- [ ] Stove
- [ ] Refrigerator
- [ ] Clean running water
- [ ] Missing any of the above

Are there any changes to the responses noted above? 
- [ ] No [ ] Yes. Explain: ________________________

14. In the past month, were you worried that your food would run out before you or your family had money to buy more? 
- [ ] No [ ] Yes. Explain: ________________________

In the past month, were there times when the food that you or your family bought just did not last and you did not have money to get more?  
- [ ] No [ ] Yes. Explain: ________________________

Do you use any of the following food resources? 
- [ ] WIC: [ ] No [ ] Yes WIC Site: ________________________
- [ ] CalFresh (food stamps)? [ ] No [ ] Yes
- [ ] Any free food, such as from food banks, pantries or soup kitchen? [ ] No [ ] Yes

Are there any changes to the food security responses noted above?  
- [ ] No [ ] Yes. Explain: ________________________

15. What kinds of physical activity do you do?
   - [ ] Review activity level with provider.
   - [ ] Client agrees to follow STT HE handout(s) (indicate date):

How often? ____________________ How long? ____________________

On an average day, are you physically active at least 30 minutes each day?  
- [ ] Yes [ ] No

On average day, do you spend over 2 hours watching a screen (TV, computer)?  
- [ ] No [ ] Yes

Has a doctor told you to limit your activity?  
- [ ] No [ ] Yes. Explain: ________________________

Client identified ways to be more active each day

Are there any changes in your activity described above? 
- [ ] No [ ] Yes. Explain: ________________________

---

**Nutrition Individualized Care Goal/plan Developed with Client**

- [ ] Client will:
- [ ] Referred to RD (date): ____________________
- [ ] Referred to (profession and date): ____________________

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**Comment**

- [ ] Update:

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**Client Identifier**
<table>
<thead>
<tr>
<th>Nutrition Assessment (ask questions in Initial, 2nd or 3rd trimester as indicated)</th>
<th>Nutrition Individualized Care Goal/plan Developed with Client</th>
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</tr>
</thead>
</table>
| 16. Complete one of these Nutrition Assessments:  
  - 24-hour Perinatal Dietary Recall  
  - Perinatal Food Group Recall  
  - Approved Food Frequency Questionnaire  
  - Complete Nutrition Assessment  
  - 24-hour Perinatal Dietary Recall or  
  - Perinatal Food Group Recall  
  - Approved Food Frequency | Client agrees to follow STT N handout(s) (indicate date):  
  - MyPlate for Moms  
  - MyPlate for Gestational Diabetes  
  - Referred to RD (date):  
  - Referred to (profession and date):  
  - Client will: | Update: |
| 17. What have you heard about breastfeeding?  
  - Not interested  
  - Thinking about it  
  - Wants to  
  - Definitely will  
  - Other:  
  - Do you know of the risks of not breastfeeding?  
  - No  
  - Yes. Explain:  
  - Is there anything that would prevent you from breastfeeding?  
  - No  
  - Yes. Explain:  
  - Have you ever breastfed or pumped breast milk for your baby?  
  - No: Why not?  
  - Yes. How long?  
  - What was your previous breastfeeding goal?  
  - What is your current breastfeeding plan?  
  - If you are going to breastfeed, who can you go to for breastfeeding help?  
  - What do you think about breastfeeding your new baby?  
  - Not interested  
  - Thinking about it  
  - Wants to  
  - Definitely will  
  - Other:  
  - What are your new questions about feeding your baby?  
  - How do you plan to feed your baby in the first month of life?  
  - Mark all that apply:  
  - Human (breast) milk  
  - Formula  
  - Other:  
  - What are your new questions about feeding your baby? | Client agrees to follow STT N handout(s) (indicate date):  
  - Nutrition and Breastfeeding – Common Questions and Answers  
  - How Does Formula Compare to Breastmilk  
  - A Guide to Breastfeeding  
  - My Action Plan for Breastfeeding  
  - My Birth Plan  
  - Breastfeeding Checklist for My Baby and Me  
  - My Breastfeeding Resources  
  - Breastfeeding and Returning to Work or School  
  - Client received local breastfeeding resources  
  - Referred to RD (date):  
  - Referred to lactation consultant:  
  - Client will: | Update: |
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<tbody>
<tr>
<td>18. Do you have any other nutrition questions or concerns?</td>
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<td>□ No □ Yes, describe:</td>
<td>Intervention: Client goal/plan:</td>
<td></td>
</tr>
<tr>
<td>□ No □ Yes, describe:</td>
<td>Intervention: Client goal/plan:</td>
<td></td>
</tr>
<tr>
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<td>Intervention: Client goal/plan:</td>
<td></td>
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19. Discussed the nutrition assessment with client and client identified the following strengths:

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<tr>
<th>Nutrition:</th>
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<tr>
<td>Minutes spent ___________________________________________ Completed by: ____________________________ Signature ____________________________ Title ____________________________ Date ____________________________</td>
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Signature of medical provider if assessor is CPHW: ____________________________________________ Signature ____________________________ Title ____________________________ Date ____________________________

20. Discussed the nutrition assessment with client and client identified the following strengths:

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