

When you welcome a new baby into your family, it is an important time to make sure you have all the support you need for health and parenting. We ask all pregnant women or parents of an infant to fill out this survey so that we can provide the best care for you here, and so that we can refer you to other services if needed. **You do not have to answer any questions if you do not want to, and all of your answers are confidential.** However, if you or a child in your home are in danger we will discuss this with you and we may need to report this information.

PART 1 | BASIC INFORMATION

Today's Date: _____

1 Name: _____

2 Your DOB: ____ / ____ / ____
Age 19 or less? Yes No

3 In which language do you want us to communicate with you?

4 Are you a recent immigrant (5 years or less) or refugee?
 Yes
 No

5 What is the highest level of school you completed?
Mark only one.
 Less than high school
 High school graduation/GED
 Some classes after high school
 College
 Graduate school

6 How would you describe your current relationship?
 Single (Unmarried/Unpartnered, divorced, widowed)
 I have a partner
 Married

7 How would you describe your current job?
 Full time (30 hours a week or more)
 Part-time
 Seasonal work
 Unemployed and looking for work
 Unemployed and not looking for work

8 How would you describe your spouse's or partner's job?
 Full time (30 hours a week or more)
 Part-time
 Seasonal work
 Unemployed and looking for work
 Unemployed and not looking for work
 No spouse or partner

PART 2 | PREGNANCY INTENTION

9 When you got pregnant with this most recent pregnancy, were you trying to get pregnant?
 Yes → Did you use medications or fertility treatments to help you get pregnant?
 Yes No
 No → How do you (or did you) feel about being pregnant?
 I'm happy about it
 I'm okay with it
 I'm not okay with it
 I have mixed feelings

10 If you are currently pregnant, do you plan to continue the pregnancy? (If NOT currently pregnant, skip to Question 11)
 Yes, and I plan to parent
 Yes, and I do not plan to parent
 No
 I'm not sure yet

11 Does (or did) your partner agree with you about whether or not to continue this pregnancy?
 Yes
 No
 I have no partner

PART 3 | ASSETS & RESOURCES

12 Do you have a regular doctor who does check-ups and sees you when you are sick?

Yes No

13 Do you have a dentist?

Yes No

14 Have you had a dental checkup in the past year?

Yes No

15 Do you get at least 7 hours of sleep each night?

Yes, usually
 Sometimes
 Almost never

16 Do you walk at least 30 minutes or do other forms of exercise at least 5 days a week?

Yes
 Sometimes
 Almost never

17 How would you describe the involvement of the father of the baby?

Very involved
 Somewhat involved
 Not involved, but I have another adult who is committed to parenting
 Not involved and no other adult is involved
 Unclear

18 Do you feel that you have the social and emotional support you need for pregnancy and parenting?

Yes
 No
 Unsure

19 Do you have someone to provide the types of help listed below if needed? Please mark each answer that applies:

Loan me money for food and bills
 Help me if I were sick and needed to be in bed
 Give me a ride to the clinic or doctor's office
 Listen to me if I needed someone to talk to
 Show me love and affection (other than a child)
 None of these apply

PART 4 | EMOTIONAL HEALTH & WELLNESS

20 Have you ever been diagnosed with depression, postpartum depression, anxiety, bipolar disorder, an eating disorder or ADHD?

Yes No

21 Over the past 2 weeks, how often have you felt down, depressed or hopeless?

Not at all More than half the days
 Several days Nearly every day

22 Over the past 2 weeks, how often have you felt that you had little interest or pleasure in doing things?

Not at all More than half the days
 Several days Nearly every day

23 In the past 2 weeks how often have you felt that your stress has made it hard to do what you need to do?

Not at all More than half the days
 Several days Nearly every day

24 Have you ever experienced discrimination (felt like you were treated worse than other people) because of race, skin color, immigration status, age, income, sex/gender, sexual orientation, religion or because you were pregnant?

Yes No

25 Have you experienced a forced separation of family members or caregivers because of deportation, immigration, jail or prison, military deployment, job requirements or other reason?

Yes No

26 We know that many people grew up in households where difficult things happened to them, and they go on to become healthy adults and loving, effective parents when they get the right support. Here is a list of things that can happen to people in childhood, and may impact their health and well-being into adulthood: physical abuse or neglect, emotional abuse or neglect, sexual abuse, loss of a parent through death, separation, divorce, prison or abandonment, witnessing violence in the household, having a parent or caregiver addicted to alcohol or drugs, having a parent or caregiver with severe mental illness, experiencing community violence or discrimination.

Have you experienced 4 or more of these as part of your childhood?

Yes No

27 Are you interested in getting more information about how discrimination, stress or trauma might affect your health or parenting?

Yes No

PART 5 | SUBSTANCE USE

We know that a lot of women struggle with drugs & alcohol for a variety of reasons, sometimes while pregnant. We ask all families these questions so we can offer support and answer any questions you may have. We are not required to report these answers to DHS/Child Welfare unless there is a child in your home at risk of abuse or neglect.

- 28 In the past year, how many times have you had 4 or more drinks in one day?
- None
 - 1 time
 - More than 1 time
- 29 Did your parents have a problem with alcohol or drugs?
- Yes
 - No
- 30 Do any of your friends have a problem with alcohol or drugs?
- Yes
 - No
- 31 Does your partner or spouse have a problem with alcohol or drugs?
- Yes
 - No
- 32 Have you had trouble with alcohol, street drugs or prescription drugs in the past?
- Yes
 - No
- 33 Have you used any street drugs (like methamphetamines, heroin, or cocaine) or taken methadone during this pregnancy?
- Yes
 - No
- 34 How many times have you taken a prescription medication like oxycodone or OxyContin, morphine, hydrocodone (Vicodin), diazepam (valium), alprazolam (Xanax), clonazepam (Clonopin), lorazepam (Ativan) or similar medications in the past 3 months?
- None
 - 1 time
 - More than 1 time
- 35 Have you had any alcohol during this pregnancy?
- Yes
 - No
- 36 Have you used tobacco or nicotine in any form (cigarettes, vaping, etc.)?
- Yes, currently
 - Yes, but I cut down with pregnancy
 - Yes, but I stopped with pregnancy
 - Yes, but I stopped a while ago
 - No
- 37 Have you used marijuana for medical or recreational purposes?
- Yes, currently
 - Yes, but I cut down with pregnancy
 - Yes, but I stopped with pregnancy
 - Yes, but I stopped a while ago
 - No

PART 6 | RELATIONSHIP HEALTH

- 38 How would you describe your current family relationships?
- Few/minor problems
 - Some problems
 - Serious problems
- 39 Does your partner talk to you in ways that make you feel bad?
- Yes, often
 - Sometimes
 - No
 - No partner
- 40 Does your partner control where you go, who you talk to, or how you spend money?
- Yes, often
 - Sometimes
 - No
 - No partner
- 41 Has your partner hurt or threatened you, or forced you to have sex?
- Yes, often
 - Sometimes
 - No
 - No partner
- 42 Does your partner mess with your birth control or try to get you pregnant when you don't want to be?
- Yes, often
 - Sometimes
 - No
 - No partner
- 43 In your current relationship, do you feel free to access any services and support you need?
- Yes, often
 - Sometimes
 - No
 - No partner

PART 7 | OTHER CHILDREN OR ADULTS IN THE HOUSEHOLD

- 44** Are there other children in the house under the age of 6 besides your new baby, for whom you are a primary caregiver?
- No
- Yes → Do any of the children you care for have special needs (such as developmental delay, learning disability or physical disability)?
- Yes No
- Do you have any concerns about the children (health, growth, development, behavior)?
- Yes No
- Have they all had a well child checkup in the past year?
- Yes No
- Have they all had a dental visit in the past year?
- Yes No

- 45** Do you have children under age 18 who are not living with you?
- Yes No

- 46** Are there other adults in the household (besides you) who have or who will have contact with your new baby?
- No
- Yes → Do any of them have serious medical problems, mental health problems, or problems with alcohol or drugs?
- Yes No
- Does anyone else in the house smoke?
- Yes No
- Do any adults in the household need assistance with education or training or finding a job?
- Yes No

PART 8 | ASSETS AND RESOURCES

- 47** In the past 3 months, how often have you worried about having enough food?
- Every day Some days
- Most days Never
- 48** In the past 3 months, how often have you worried about having a safe and stable place to live?
- Every day Some days
- Most days Never
- 49** In the past 3 months, how often have you worried about having good childcare?
- Every day Some days
- Most days Never
- 50** In the past 3 months, how often has transportation limited you in doing what you need to do?
- Every day Some days
- Most days Never
- 51** In the past 3 months, how often have you had trouble paying for basic living expenses (like housing, food, clothes)?
- Every day Some days
- Most days Never

- 52** Programs or services you are already connected with or want to be connected with (optional)
- | | I am already connected | I want to be connected |
|---|------------------------|------------------------|
| Child Birth Classes | <input type="radio"/> | <input type="radio"/> |
| Child Care Resource & Referral | <input type="radio"/> | <input type="radio"/> |
| Counseling/ Mental Health Clinic | <input type="radio"/> | <input type="radio"/> |
| Domestic violence support or shelter | <input type="radio"/> | <input type="radio"/> |
| Early Head Start/Head Start | <input type="radio"/> | <input type="radio"/> |
| Emergency Food (food bank) | <input type="radio"/> | <input type="radio"/> |
| Food stamps (SNAP)
Oregon Trail card | <input type="radio"/> | <input type="radio"/> |
| Home visitors (nurse or educator that comes to your home to help with medical or parenting support) | <input type="radio"/> | <input type="radio"/> |
| Parenting Classes | <input type="radio"/> | <input type="radio"/> |
| Self Sufficiency, TANF (cash assistance) | <input type="radio"/> | <input type="radio"/> |
| Housing support | <input type="radio"/> | <input type="radio"/> |
| Substance use treatment | <input type="radio"/> | <input type="radio"/> |
| Teen Parent Services | <input type="radio"/> | <input type="radio"/> |
| Victim's Assistance | <input type="radio"/> | <input type="radio"/> |
| WIC or nutrition supplementation | <input type="radio"/> | <input type="radio"/> |
| Breastfeeding Support | <input type="radio"/> | <input type="radio"/> |
| Employment Assistance | <input type="radio"/> | <input type="radio"/> |
| Rent/Energy Assistance | <input type="radio"/> | <input type="radio"/> |
| Other: _____ | <input type="radio"/> | <input type="radio"/> |