CPSP Integrated Initial [I] and [2]& [3]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

Pregnancy Information

DOB:_____Age:_____

EDD:_____Weeks Gestation_____

Grav:_____Para:_____TAB:_____SAB:_____

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:

Psychosocial Needs/Risks/Concerns *(ask questions in*	**Psychosocial Individualized Care Plan Developed with Client**	**Com-**
1. Is this a planned pregnancy? ❑Yes ❑ No, describe: [I] 2. Is this a wanted pregnancy? ❑Yes ❑ No, describe: 3. Are you considering abortion/adoption? ❑No ❑ Yes, describe:	❑ Client states she understands STT PSY, ❑ **Uncertain about Pregnancy, ❑ Choices** ❑ Client goal/plan: ❑ Informed of CA Safe Surrender Law ❑ Consult with OB provider ❑ Referred to/for:	
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 [I] ❑ Client wishes more support, identified sources:	❑ Referred to/for: ❑ Client goal/plan:	
5. What are your goals for this pregnancy?: ❑ healthy baby [I] ❑ other:	❑ Referred to/for: ❑ Client goal/plan:	
6. Have you had issues with previous pregnancies? ❑ N/A [I] ❑ No ❑ Yes, describe: ❑ Would you like information on how to reduce risk in this pregnancy? ❑Yes ❑ No	❑ Client goal/plan: ❑ Consult with OB provider	
7. Have you had a previous pregnancy loss/infant death? [I] ❑No ❑ Yes, describe:	❑ Client goal/plan: ❑ Client states aware of support resources ❑ Referred to/for:	
8. Members of household (not including client) [I] Number of adults: _____ Relationship to client: Number of children: _____ Relationship to client: 9. Do all of your children live with you? ❑ N/A ❑ Yes ❑ No, describe:	❑ Client goal/plan: ❑ Referred to/for	
10. Are you currently receiving services from a local agency such [I] ❑ No ❑Yes, describe:	❑ Client goal/plan: ❑ Obtained client's written permission to share information with: Agency:_____ Contact person:_____ Phone: _____ Fax:_____	

Client Identifier

Psychosocial Needs/Risks/Concerns *(ask questions in Initial, 2nd or 3rd trimester as indicated)*	**Psychosocial Individualized Care Plan Developed with**	**Com-ment**
❑ No ❑ Yes, describe: 2	❑ Client goal/plan: ❑ Obtained client's written permission to share information with: Agency:_____ Contact person:_____ Phone: _____ Fax:_____	
❑ No ❑ Yes, describe: 3	❑ Client goal/plan: ❑ Obtained client's written permission to share information with: Agency:_____ Contact person:_____ Phone: _____ Fax:_____	
11. Have you ever seen a counselor for personal or family issues or support? ❑ No ❑ Yes, describe: I Do you need counseling now? ❑ No ❑ Yes, describe:	❑ Client goal/plan: ❑ Referred to/for:	
12. Have you ever been emotionally, physically, or sexually abused by a partner or someone close to you? ❑ No ❑ Yes, describe: I 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: Do you feel in danger now? ❑ No ❑ Yes, describe:	❑ Client Goal/plan: ❑ States understands STT PSY **Cycle of Violence** ❑ Made safety goal/plan ❑ Client states understands legal options ❑ Agrees to follow STT PSY: **Safety When Preparing to Leave** ❑ Referred to/for: ❑ If minor, completed mandated report, date:_____ ❑ If current injuries/adult, reported to OB provider ❑ Reported to law enforcement, date:_____ ❑ In contact with law enforcement/agency already:	
14. Are you afraid of your partner or ex-partner? I ❑ No ❑ Yes, describe: 2 ❑ No ❑ Yes, describe: 3 ❑ No ❑ Yes, describe:	❑ Client goal/plan: states understands: ❑ STT PSY **Cycle of Violence** ❑ What to do in an emergency ❑ Legal options. ❑ Agrees to follow STT PSY: **Safety When Preparing to Leave** ❑ Made safety plan ❑ Referred to/for: Update: Update:	
15. Are you having any other personal or family challenges? I ❑ No ❑ Yes, describe: 2 ❑ No ❑ Yes, describe: 3 ❑ No ❑ Yes, describe:	❑ Client states aware of support resources: ❑ Client goal/plan: ❑ Referred to/for: ❑ Update: ❑ Update:	
16. Who do you turn to for emotional support? I ❑ FOB/partner ❑ family member: ❑ friend: ❑ other: ❑ No one, describe: 2 ❑ No one, describe: 3 ❑ No one, describe:	❑ Client identified possible sources of support ❑ Client goal/plan: ❑ Referred to/for: ❑ Update: ❑ Update:	

Client Identifier

Psychosocial Needs/Risks/Concerns *(ask questions in Initial, 2nd or 3rd trimester as indicated)*	**Psychosocial Individualized Care Plan Developed with Client**	**Com-ment**
17. Do you often feel down, sad or hopeless? ❑No [I] ❑ Yes, describe: Do you often feel irritable, restless or anxious? ❑No ❑ Yes, describe: Have you lost interest or pleasure in doing things that you used to enjoy? ❑ No ❑ Yes, describe: 2 Ask the above questions, describe response: 3 Ask the above questions, describe response:	❑ Screen for signs of emotional concerns at future appointments ❑ Referred to ❑provider or ❑psychosocial consultant for assessment and intervention ❑ Client goal/plan: ❑ Referred to: Update: Update:	
18. Did your parents use alcohol or drugs? ❑No ❑ Yes, describe: [I] 19. Does your partner use alcohol or drugs? ❑ N/A ❑No ❑ Yes, describe:	❑ Client states understands risks ❑ Client goal/plan: ❑ Referred to/for:	
20. Before you knew you were pregnant, how much beer/wine/liquor did you drink? ❑ None [I] ❑ was drinking _____ _____a day/wk./month amount type of alcohol Are you drinking now? ❑ No ❑ Yes, describe: _____ _____a day/wk./month amount type of alcohol Do you drink a lot at one time? (4 or more drinks in about 2 hours) ❑ No ❑ Yes :_____a day/wk./month times	❑ Client states understand risks ❑ Client goal/plan: ❑ Follow STT PSY, **Baby Can't Say No** ❑Follow STT PSY, **Drugs and Alcohol, when you want to STOP using** ❑ Client states decided not to drink alcohol ❑ Agreed to cut down to how much: _____ Client stated confidence in quitting/cutting down: (circle): 1 2 3 4 5 6 7 8 9 10 ❑ Support person: ❑ Consult with OB provider ❑ Referred to/for:	
2 Are you drinking now? ❑ No ❑ Yes, describe: _____ _____a day/wk./month amount type of alcohol Do you drink a lot at one time? (4 or more drinks in about 2 hours) ❑ No ❑ Yes :_____a day/wk./month times	Update:	
3 Are you drinking now? ❑ No ❑ Yes, describe: _____ _____a day/wk./month amount type of alcohol Do you drink a lot at one time? (4 or more drinks in about 2 hours) ❑ No ❑ Yes :_____a day/wk./month times	Update:	
21. Before you knew you were pregnant, how much tobacco did [I] you smoke (including e-cigarettes)? ❑None ❑ was smoking (amount, type, how often) _____ _____ Are you smoking now? ❑ No ❑ Stopped smoking and is not smoking now ❑ Cut down to _____	❑ Client states understands risks ❑ Client goal/plan: ❑ Will cut down to how much_____ ❑ Will quit when_____ ❑Client's confidence in quitting (circle): 1 2 3 4 5 6 7 8 9 10 ❑ Identified support person:	

Client Identifier

Psychosocial Needs/Risks/Concerns *(ask questions in Initial, 2nd or 3rd trimester as indicated)*	**Psychosocial Individualized Care Plan Developed with Client**	**Com-ment**
❑ Smoking about the same amount	❑ States understands STT HE: **You can Quit Smoking** ❑ Referred to CA Smokers' Helpline 1-800-NoButts ❑ Consult with OB provider ❑ Referred to/for:	
2 Are you smoking now? ❑Yes ❑ No ❑ Stopped smoking and is not smoking now ❑ Cut down to_____ ❑ Smoking about the same amount	Update:	
3 Are you smoking now? ❑Yes ❑ No ❑ Stopped smoking and is not smoking now ❑ Cut down to_____ ❑ Smoking about the same amount	Update:	
22. Do people smoke around you? ❑ No I ❑ Yes, about _____hours per day Number 2 ❑ No ❑ Yes, about _____hours per day Number 3 ❑ No ❑ Yes, about _____hours per day Number	Client goal/plan: ❑ States will avoid smoke ❑ States will talk to others about keeping home and car smoke-free ❑ Discussed STT HE section, *Second Hand Smoke*❑ **You can Quit Using Drugs or Alcohol** ❑ Update: ❑ Update:	
23. Before you knew you were pregnant, how much did you usually use marijuana or other drugs? ❑ None I ❑ Was using:_____ _____a day/wk./month Are you using drugs now? ❑ No ❑ Yes, now using:_____ _____a day/wk./month amount drug	❑ Client verbalizes understanding of risks. Client goal/plan: ❑Client understands STT HE: **You can Quit Using Drugs or Alcohol** ❑ 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:_____	
2 Are you using drugs now? ❑ No ❑ Yes, using:_____ _____a day/wk./month amount drug	Update:	
Are you using drugs now? ❑No ❑ Yes, now using:_____ _____a day/wk./month amount drug 3	Update:	
24. What is your source of financial support? I ❑ Self, type of work: ❑ FOB/partner, type of work: ❑ Family member/ friend: ❑ CalWORKS ❑ SSI ❑ other:	❑ Client Goal/plan: ❑ Referred to/for:	

Client Identifier

Psychosocial Needs/Risks/Concerns *(ask questions in Initial, 2nd or 3rd trimester as indicated)*	**Psychosocial Individualized Care Plan Developed with Client**	**Com-ment**
❑ Concerns, describe: 2 ❑ Concerns, describe: 3 ❑ Concerns, describe:	 Update: Update:	
25. Where do you live? I ❑ Apartment/house ❑ other: _____ ❑ Concerns, describe: 2 ❑ Concerns/changes, describe: 3 ❑ Concerns/changes, describe:	❑ Client Goal/plan: ❑ Referred to/for: Update: Update:	
26. Any other questions or concerns? I ❑ None ❑ Yes, describe: 2 ❑ None describe: 3 ❑ None, describe:	❑ Client Goal/plan: ❑ Referred to/for: Update: Update:	
27. Discussed results of assessment with client and client identified the following strengths: I 2 3		

Psychosocial

I 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

Client Identifier

Health Education

Health Education Learning Needs/Risks/Concerns (ask questions in Initial, 2nd or 3rd trimester as indicated in each cell)	**Health Education Individualized Care Plan Developed with Client**	**Com-ment**
1. How do you like to learn?: ❑ Text message reminders ❑ Reading/handouts ❑ Classes/groups ❑ Individual teaching ❑ Videos ❑ Other: How well do you write/read? ❑ good/fair ❑ poor/non-reader 2. Do you have someone you can talk to about what we discussed today? ❑ Yes, identify _____ ❑ No	❑ Will use following learning methods: ❑ Client wishes adapted education methods, such as using pictures or low literacy materials ❑ Will sign up for Text4Baby ❑ Client stated she will involve a support person by sharing educational materials after her appointments Name/relationship:	
3. What language do you prefer to speak? _____ What language do you prefer to read? _____ In what language would you like materials?_____	❑ Provide materials in _____language.	
4. What was the last grade you completed?_____ ❑ Less than high school/GED	❑ Referred to:	
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: Do you know how to get other health care services? ❑Yes ❑ No, comments:	❑ Client verbalizes understanding of available health care services ❑Provide a copy of her medical records if she needs to leave the area. ❑ Referred to:	
6. Do you have any physical difficulties that affect learning? (Such as vision, hearing, learning disabilities)? ❑No ❑ Yes, describe:	❑ Client wishes adapted health education methods ❑ Consult with OB provider ❑ Referred to/for:	
7. Who gives you advice about your pregnancy? ❑ No one ❑ mother ❑ mother-in-law ❑ grandmother ❑ partner ❑ sister ❑ friend: ❑ other: What are the most important things they have told you?	❑ Referred to support group: _____ ❑ Client stated she will consult with OB provider regarding the following possibly harmful advice:	
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	Client goal/plan: ❑ Follow STT HE **Pregnant? Steps for a Healthy Baby ❑Keep Safe at Work** ❑ Consult with OB provider re: ❑ Client has MotherToBaby California information (866) 626-6847 www.mothertobabyca.org ❑ Mailed or faxed MotherToBaby client referral form	
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 d	❑ 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:	
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:_____ ❑ None, follow up at next visit	❑ Reviewed the following items with client: ❑ Client will discuss the following with OB provider: ❑ Reviewed the following items with client:	

Client Identifier

Health Education Learning Needs/Risks/Concerns (ask questions in Initial, 2nd or 3rd trimester as indicated in each cell)	**Health Education Individualized Care Plan Developed with Client**	**Com-ment**
2 ❑ No, follow up at next visit ❑ Yes, describe topics: 3 ❑ No , follow up at next visit ❑ Yes, describe topics:	❑ Client will discuss the following with OB provider: ❑ Reviewed the following items with client: ❑ Consult with OB provider re:	
11. Have you had a dental check-up in the past 12 months? I Date: _____ ❑ No: Do you have any painful or loose teeth, bleeding gums or bad taste or smell in mouth? ❑No ❑ Yes, describe: 2 Do you have any painful or loose teeth, bleeding gums or bad taste or smell in mouth? ❑No ❑ Yes, describe: : *If referred: Have you seen a dentist? Date:*_____ 3 Do you have any painful or loose teeth, bleeding gums or bad taste or smell in mouth? ❑No ❑ Yes, describe: *If referred: Have you seen a dentist? Date:*_____	Client Goal/plan: Follow STT HE ❑ **Prevent Gum Problems** ❑ **See a Dentist** ❑ **Keep Teeth Healthy** ❑ Consult with OB provider ❑ Completed Prenatal Dental Referral, date: _____ ❑ Referred to/for: ❑ Update: ❑ Update:	
12. How will you come for appointments? I ❑ bus ❑ car ❑ walk ❑ other: ❑ Any transportation issues? Describe: 2 ❑ Any transportation issues? Describe: 3 ❑ Any transportation issues? Describe:	❑ Client goal/plan: ❑ Client goal/plan: ❑ Client goal/plan:	
13. Do you know how to use a seat belt when pregnant? I ❑ Yes ❑ No Do you always use a seat belt? 2 ❑ Yes ❑ No Do you always use a seat belt? 3 ❑ Yes ❑ No	❑ Client understands safe seat belt use per STT HE **Pregnant? Steps for a Healthy Baby** ❑ Client understands safe seat belt use per STT HE **Pregnant? Steps for a Healthy Baby** ❑ Client understands safe seat belt use per STT HE **Pregnant? Steps for a Healthy Baby**	
14. 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? I ❑ Yes ❑ No, list gaps: 2 Discussed above items: ❑ Yes ❑ No, list gaps: 3 Discussed above items ❑ Yes ❑ No, list gaps:	Client goal/plan: Follow: STT HE ❑ **Danger Signs in Welcome to Pregnancy Care** ❑ **If Labor Starts Too Early** ❑ **What You Need to Know About Labor Induction** ❑ Consult with OB provider Client goal/plan: Follow: STT HE ❑ **Danger Signs in Welcome to Pregnancy Care** ❑ **If Labor Starts Too Early** ❑ **What You Need to Know About Labor Induction** ❑ Consult with OB provider Client goal/plan: ❑ Client is more than 28 weeks and will follow ❑ STT HE **Kick Counts** ❑ **Danger Signs in Welcome to Pregnancy Care** ❑ **If Labor Starts Too Early** ❑ **What You Need to Know About Labor Induction** ❑ Consult with OB provider	
15. What are your plans for labor and delivery? 3 labor support person ❑ Yes ❑ No signs of labor, when to call ❑ Yes ❑ No goal/plans for transportation to hospital ❑ Yes ❑ No childcare goal/plans for other kids ❑ Yes ❑ No	❑ Referred to hospital tour: Name of hospital: _____ ❑ Referred to childbirth preparation class_____ ❑ Understands options for labor and delivery ❑ Reviewed/completed STT NUT **My Birth Plan** ❑ Client understands signs of labor, when to call ❑ Client has support person:	

Client Identifier

Health Education Learning Needs/Risks/Concerns (ask questions in Initial, 2nd or 3rd trimester as indicated in each cell)	**Health Education Individualized Care Plan Developed with Client**	**Com-ment**
16. Do you have any questions about how to take care of yourself after delivery? ❑ No ❑ Yes, describe: ❑ Discussed importance of postpartum care, procedure for making appointments.	❑ Client has made arrangements for transportation to hospital ❑ Client has made arrangements for childcare for other kids ❑ Client has no support person—notified _____ ❑ Client understands importance of postpartum care and has agreed to make appointment	
17. Do you know about infant: ❑ care, ☐safety, ☐ illness, ☐ safe sleep, ☐ immunizations? (3) 18. Do you have the following items? ❑ baby supplies/clothing/safe sleeping ❑ child passenger safety seat ❑ Child care, if returning to work or school ❑Needs:	Client Goal/plan: Follow: STT HE ❑ **Keep Your New Baby Safe and Healthy** ❑ **When Newborn is Ill** ❑ **Baby Needs Immunization** ❑ If multiples, **Getting Ready for Multiples, Baby Products, Discounts, and Coupons** ❑ Client has car seat/understands car seat requirements ❑ Client understands crib safety (crib slats no more than 2 3/8 inches apart and other tips) ❑ Advised to call: ❑ Referred to/for:	
19. Have you chosen a doctor for the baby? ❑ Yes ❑ No (3) Name of provider_____	❑ Referred to pediatric provider: _____ ❑ Referred to CHDP provider: _____	
20. Do you plan to have more children? ❑ Yes ❑ No How many? _____ (3) How far apart? _____ What birth control method(s) are you interested in? Do you have any concerns about your ability to use birth control? ❑ No ❑ Yes, describe: ❑ Remembering to use birth control ❑ Concerned about failure ❑ Partner interferes with birth control	❑ Has family planning provider ❑ Discussed birth control methods, including long acting contraceptives (LARCs) ❑ Preferred contraceptive method: _____ ❑ Referred to family goal/planning provider ❑ Client will consult with obstetric provider if planning to get pregnant again before this baby is 18 months old. ❑ Client will consult with OB provider if client's partner does not support her use of birth control. ❑ Client understands there are methods partner does not have to know about.	
21. Do you have a doctor you can go to for regular medical checkups? _____ (3) ❑ No	❑ Client will call: Name:_____ ❑ Referred to/for:	
22. Do you have health insurance for care after your pregnancy? (3) ❑ Yes ❑ No	❑ Referred to eligibility worker, Covered CA or safety net	
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.)* ❑No ❑ Yes, describe: (3)	Client goal/plan: ❑ Make appointment with primary care provider ❑ Referred to/for:	
24. Do you have any other questions or concerns? [I] ❑ No ❑ Yes, describe: (2) ❑ No ❑ Yes, describe: (3) ❑ No ❑ Yes, describe:	Client goal/plan: Client goal/plan: Client goal/plan:	
25. Reviewed health education assessment with client and client identified the following strengths: [I]		

Client Identifier

Health Education Learning Needs/Risks/Concerns (ask questions in Initial, 2nd or 3rd trimester as indicated in each cell)	**Health Education Individualized Care Plan Developed with Client**	**Com-ment**
2 3		

Health Education:

I 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

Client Identifier

Nutrition

Nutrition Assessment (ask questions in Initial, 2nd or 3rd trimester as indicated)	**Nutrition Individualized Care Goal/plan Developed with Client**	**Com-ment**
Anthropometric: Height, Weight, & Body Mass Index (BMI)		
1. Pre-pregnancy weight: _____ lbs. Height_____BMI_____ I 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	*Client states understanding of:* ❑ Pre-pregnancy weight category (BMI) ❑ Recommended weight gain range for pre pregnancy weight category is between ____ lbs. and _____lbs. ❑ Plotting and discussing weight gain at every visit ❑ Client's weight gain goal for this pregnancy: _____ ❑ Referred to RD (date): _____ ❑ Referred to (profession and date): _____	
2. Current weight gain:_____lbs I ❑ 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?	❑Discussed plotting and reviewing weight gain at every visit Client agrees to follow STT NUT handout(s) (indicate date): ❑ **Tips To Gain Weight** _____ ❑ **Tips to Slow Weight Gain** _____ ❑ Referred to RD (date): _____ ❑ Referred to/date: _____ ❑ Client will:	
2 Current weight gain: ❑ Appropriate ❑ Excessive ❑ Inadequate How do you feel about the weight you have gained so far with this pregnancy?	❑ Referred to RD (date): _____ ❑ Referred to/date: _____ ❑ Client will:	
3 Current weight gain: ❑ Appropriate ❑ Excessive ❑ Inadequate How do you feel about the weight you have gained so far with this pregnancy?	❑ Referred to RD (date): _____ ❑ Referred to/date: _____ ❑ Client will:	
Biochemical: Lab Values		
3. Consult with provider regarding whether there are abnormal lab values and treatment prescribed. I HGB _____ HCT _____ Fasting Blood Glucose_____ Date of consultation with provider_____ Abnormal lab values: ❑ No ❑ Yes, Explain:	If approved by provider, review with client: Client agrees to follow STT N handout(s) (indicate date): ❑ **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** _____ ❑**Folic Acid: Every Woman, Every Day**_____ ❑ **Vitamin B12 is Important**_____ ❑ Anemia, iron prescribed ❑ Referred to RD (date): _____ ❑ Client will:	
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:	❑ Referred to RD (date): _____ ❑ Client will: ❑ See Question 6 for gestational diabetes interventions.	
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:	❑ Referred to RD (date): _____ ❑ Client will:	

Client Identifier

Nutrition Assessment (ask questions in Initial, 2nd or 3rd trimester as indicated)	**Nutrition Individualized Care Goal/plan Developed with Client**	**Com-ment**
Clinical		
4. [I] Blood Pressure_____/_____ [2] Blood Pressure_____/_____ [3] 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? [I] ❑ nausea ❑ vomiting ❑ leg cramps ❑ gas ❑ heartburn ❑ constipation ❑ hemorrhoids ❑ swelling of feet or hands ❑ dizziness ❑ diarrhea ❑ other:_____ Do any of these discomforts keep you from eating as you normally would? ❑ No ❑ Yes. Explain: [2] Are there any changes to nutrition- related discomforts? ❑ No ❑Yes. Explain: [3] Are there any changes to nutrition- related discomforts? ❑ No ❑Yes. Explain:	❑ Discussed 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: ❑ Discussed symptoms with provider ❑ Referred to RD (date): _____ ❑ Referred to (profession and date):_____ ❑ Client will:	

Client Identifier

Nutrition Assessment (ask questions in Initial, 2nd or 3rd trimester as indicated)	**Nutrition Individualized Care Goal/plan Developed with Client**	**Com-ment**
6. Do you have any of these nutrition-related health issues? I ❑ 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:	❑ 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:	
2 Are there any new nutrition-related health issues? ❑ No ❑ Yes. Explain:	❑ Discussed risks with provider ❑ Referred to RD (date): _____ ❑ Referred to (profession and date): _____ ❑ Client will:	
3 Are there any new nutrition-related health issues? ❑ No ❑ Yes. Explain:	❑ Discussed risks with provider ❑ Referred to RD (date): _____ ❑ Referred to (profession and date): _____ ❑ Client will:	
Dietary		
7. Are you currently taking any of the following? I Which one? / How much /often? ❑ Iron _____ _____ ❑ Folic Acid _____ _____ ❑ Prenatal vitamins/minerals _____ _____ ❑ Other vitamins or mineral _____ _____ ❑ Home remedies or herbs/teas _____ _____ ❑ Liquid or powdered supplements _____ _____ ❑ Laxatives _____ _____ ❑ Prescription medicines _____ _____ ❑ Antacids _____ _____ ❑ Over-the-counter medicines _____ _____	❑ 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:	
2 Are there any changes to supplements/medications noted above? ❑ No ❑ Yes. Explain:	❑ Discussed all new findings with provider Date:_____ ❑ Referred to RD (date): _____ ❑ Referred to (profession and date):_____ ❑ Client will take prenatal vitamins ❑ Client will:	
3 Are there any changes to supplements/medications noted above? ❑ No ❑ Yes. Explain:	❑ Update:	

Client Identifier

Nutrition Assessment (ask questions in Initial, 2nd or 3rd trimester as indicated)	**Nutrition Individualized Care Goal/plan Developed with Client**	**Com-ment**
8. Have you had any changes in your appetite or eating habits since becoming pregnant? I ❑ No ❑ Yes. Explain: 2 Have you had any changes in your appetite or eating habits? ❑ No ❑ Yes. Explain: 3 Have you had any changes in your appetite or eating habits? ❑ No ❑ Yes. Explain:	❑ Referred to RD (date): _____ ❑ Referred to (profession and date): _____ ❑ Client will: ❑ Referred to RD (date): _____ ❑ Referred to (profession and date): _____ ❑ Client will: ❑ Referred to RD (date): _____ ❑ Referred to (profession and date): _____ ❑ Client will:	
9. Do you limit or avoid any food or food groups (such as meat or dairy)? I ❑ No ❑ Yes. Explain: Why do you avoid these foods? ❑ Do not like ❑ Allergy ❑ Physician advice ❑ Intolerance ❑ Personal Choice ❑ Other: _____ 2 Are there any changes to food groups avoided? ❑ No ❑ Yes. Explain: 3 Are there any changes to food groups avoided? ❑ No ❑ Yes. Explain:	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**_____ ❑ **Get The Iron You Need** _____ ❑ **If You Need Iron Pills**_____ ❑**Iron Tips**_____❑**Iron Tips: Take Two**_____ ❑**My Action Plan for Iron**_____ ❑ **When You Are a Vegetarian: What Do You Need To Know** _____ ❑ **Choose Healthy Foods**_____ ❑ **MyPlate for Moms/My Nutrition Plan for Moms** _____ ❑ **MyPlate for Gestational Diabetes** _____ ❑ Referred to RD (date):_____ ❑ Referred to (profession and date): _____ ❑ Client will: ❑ Referred to RD (date): _____ ❑ Referred to (profession and date): _____ ❑ Client will: ❑ Referred to RD (date): _____ ❑ Referred to (profession and date): _____ ❑ Client will:	
10. Have you fasted during this pregnancy or do you plan to fast? I ❑ No ❑ Yes. Explain how long and how often: 2 ❑ No ❑ Yes. Explain how long and how often: 3 ❑ No ❑ Yes. Explain how long and how often:	❑ Referred to RD (date): _____ ❑ Referred to (profession and date): _____ ❑ Client will: Update: Update:	
11. Do you ever eat any of the following: I ❑ 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 2 Are there any changes to food choices noted above? ❑ No ❑ Yes. Explain: 3 Are there any changes to food choices noted above? ❑ No ❑ Yes. Explain:	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**_____ ❑ Referred to RD (date):_____ ❑ Referred to/date: _____ ❑ Client will: Update: Update:	

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Nutrition Assessment (ask questions in Initial, 2nd or 3rd trimester as indicated)	**Nutrition Individualized Care Goal/plan Developed with Client**	**Com-ment**
12. Do you eat or have you craved any of the following? I ❑ Clay or dirt ❑ Laundry starch ❑ Cornstarch ❑ Ice or freezer frost ❑ Plaster or paint chips ❑ Other non-food item:_____ 2 Are there any changes to non-food cravings noted above? ❑ No ❑ Yes. Explain: 3 Are there any changes to non-food cravings noted above? ❑ No ❑ Yes. Explain:	❑ Client will: ❑ Referred to RD (date):_____ ❑ Referred to/date: _____ Update: Update:	
13. Do you have the following? I ❑ Oven ❑ Electricity ❑ Microwave ❑ Stove ❑ Refrigerator ❑Clean running water ❑ Missing any of the above 2 Are there any changes to the responses noted above? ❑ No ❑ Yes. Explain: 3 Are there any changes to the responses noted above? ❑ No ❑ Yes. Explain:	Client agrees to follow STT N handout(s) (indicate date): ❑ **Tips for Cooking and Storing Food** _____ ❑ **When You Cannot Refrigerate, Choose These Foods** _____ ❑ **Tips for Keeping Food Safe** _____ ❑ Referred to RD (date):_____ ❑ Referred to (profession and date): _____ ❑ Client will: Update: Update:	
14. Within the past 12 months, were you worried that your food would run out before you or your family had money to buy more? I ❑ No ❑ Yes. Explain: Within the past 12 months, 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 2 Are there any changes to the food security responses noted above? ❑ No ❑ Yes. Explain: 3 Are there any changes to the food security responses noted above? ❑ No ❑ Yes. Explain:	Client agrees to follow STT N handout(s) (indicate date): ❑ **Tips For Healthy Food Shopping**_____ ❑ **You can Buy Healthy Food on a Budget**_____ ❑ **You Can Stretch Your Dollars: Choose These Easy Meals and Snacks** _____ ❑ Referred client to WIC ❑ Referred client to CalFresh (Food Stamps) ❑ Referred client to local emergency food resources ❑ Referred to RD (date): _____ ❑ Referred to (profession and date): _____ ❑ Client will: Update: Update:	
15. What kinds of physical activity do you do?_____ I 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 2 Are there any changes in your activity described above? ❑ No ❑Yes. Explain: Are there any changes in your activity described above? 3 ❑ No ❑ Yes. Explain:	☐ Review activity level with provider. ☐ Client agrees to follow STT HE handout(s) (indicate date): ❑ **Stay Active When Pregnant** _____ ❑ **Keep Safe When You Exercise** _____ ❑ **Exercises to Do When You are Pregnant** _____ ❑ Client identified ways to be more active each day ❑ Referred to RD (date): _____ ❑ Referred to (profession and date): _____ ❑ Client will: Update: Update:	

Client Identifier

Nutrition Assessment (ask questions in Initial, 2nd or 3rd trimester as indicated)	**Nutrition Individualized Care Goal/plan Developed with Client**	**Com-ment**
16. Complete one of these Nutrition Assessments: ❑ 24-hour Perinatal Dietary Recall ❑ Perinatal Food Group Recall ❑ Approved Food Frequency Questionnaire Complete Nutrition Assessment 2 ❑ 24-hour Perinatal Dietary Recall or ❑ Perinatal Food Group Recall ❑ Approved Food Frequency 3 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: Update:	
17. What have you heard about breastfeeding? I _____ _____ _____ What do you think about breastfeeding your new baby? ❑ Not interested ❑ Thinking about it ❑ Wants to ❑ Definitely will ❑ Other_____ Do you know of the risks of not breastfeeding? ❑ No ❑Yes. 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?_____-_____ 2 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? _ _____ 3 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: Update:	

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Nutrition Assessment (ask questions in Initial, 2nd or 3rd trimester as indicated)	**Nutrition Individualized Care Goal/plan Developed with Client**	**Com-ment**
18. Do you have any other nutrition questions or concerns? I ❑ No ❑ Yes, describe: 2 ❑ No ❑ Yes, describe: 3 ❑ No ❑ Yes, describe:	Intervention: Client goal/plan: Intervention: Client goal/plan: Intervention: Client goal/plan	
20. Discussed the nutrition assessment with client and client identified the following strengths: I 2 3		

Nutrition:

I 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