CPSP Integrated Initial [1] 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

Grav:__________Para:_________TAB:_________SAB:___________

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:

Psychosocial Needs/Risks/Concerns *(ask questions in*	**Psychosocial Individualized Care Plan Developed with Client**	**Com-**
[1] 1. Is this a planned pregnancy? ❑Yes ❑ No, describe: 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:	
[1] 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 ❑ Client wishes more support, identified sources:	❑ Referred to/for: ❑ Client goal/plan:	
[1] 5. What are your goals for this pregnancy?: ❑ healthy baby ❑ other:	❑ Referred to/for: ❑ Client goal/plan:	
[1] 6. Have you had issues with previous pregnancies? ❑ N/A ❑ No ❑ Yes, describe: ❑ Would you like information on how to reduce risk in this pregnancy? ❑Yes ❑ No	❑ Client goal/plan: ❑ Consult with OB provider	
[1] 7. Have you had a previous pregnancy loss/infant death? ❑No ❑ Yes, describe:	❑ Client goal/plan: ❑ Client states aware of support resources ❑ Referred to/for:	
[1] 8. Members of household (not including client) 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	
[1] 10. Are you currently receiving services from a local agency such ❑ 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**
⚠2 ❑ No ❑ Yes, describe:	❑ Client goal/plan: ❑ Obtained client's written permission to share information with: Agency:_____ Contact person:_____ Phone: _____ Fax:_____	
⚠3 ❑ No ❑ Yes, describe:	❑ Client goal/plan: ❑ Obtained client's written permission to share information with: Agency:_____ Contact person:_____ Phone: _____ Fax:_____	
11. I Have you ever seen a counselor for personal or family issues or support? ❑ No ❑ Yes, describe: 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. [I] Do you often feel down, sad or hopeless? ❑No ❑ 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. [I] Did your parents use alcohol or drugs? ❑No ❑ Yes, describe: 19. Does your partner use alcohol or drugs? ❑ N/A ❑No ❑ Yes, describe:	❑ Client states understands risks ❑ Client goal/plan: ❑ Referred to/for:	
20. [I] Before you knew you were pregnant, how much beer/wine/liquor did you drink? ❑ None ❑ was drinking ______ (amount) __________ (type of alcohol) a day/wk./month Are you drinking now? ❑ No ❑ Yes, describe: ________ (amount) __________ (type of alcohol) a day/wk./month Do you drink a lot at one time? (4 or more drinks in about 2 hours) ❑ No ❑ Yes :_________ (times) a day/wk./month	❑ 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: ________ (amount) __________ (type of alcohol) a day/wk./month Do you drink a lot at one time? (4 or more drinks in about 2 hours) ❑ No ❑ Yes :_________ (times) a day/wk./month	Update:	
[3] Are you drinking now? ❑ No ❑ Yes, describe: ________ (amount) __________ (type of alcohol) a day/wk./month Do you drink a lot at one time? (4 or more drinks in about 2 hours) ❑ No ❑ Yes :_________ (times) a day/wk./month	Update:	
21. [I] Before you knew you were pregnant, how much tobacco did 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:	

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. I 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. I 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. I 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: I 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. I 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. I 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? I ❑ 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. I 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 2: Do you always use a seat belt? ❑ Yes ❑ No 3: Do you always use a seat belt? ❑ 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? 2 Current weight gain: ❑ Appropriate ❑ Excessive ❑ Inadequate How do you feel about the weight you have gained so far with this pregnancy? 3 Current weight gain: ❑ Appropriate ❑ Excessive ❑ Inadequate How do you feel about the weight you have gained so far with this 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: ❑ Referred to RD (date): _______________ ❑ Referred to/date: ___________________ ❑ Client will: ❑ 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: 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:	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: ❑ Referred to RD (date): ______________________ ❑ Client will: ❑ See Question 6 for gestational diabetes interventions. ❑ 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:	❑ 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): _______________	
[2] Are there any changes to nutrition- related discomforts? ❑ No ❑Yes. Explain:	❑ Discussed symptoms with provider ❑ Referred to RD (date): _______________ ❑ Referred to (profession and date): ______________ ❑ Client will:	
[3] Are there any changes to nutrition- related discomforts? ❑ No ❑Yes. Explain:	❑ 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:	❑ Referred to RD (date): ________________ ❑ Referred to (profession and date): ________________ ❑ Client will:	
(2) 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:	
(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:	
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: __________________________________	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:	
(2) Are there any changes to food groups avoided? ❑ No ❑ Yes. Explain:	❑ Referred to RD (date): ___________________________ ❑ Referred to (profession and date): __________________ ❑ Client will:	
(3) Are there any changes to food groups avoided? ❑ No ❑ Yes. Explain:	❑ 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:	❑ Referred to RD (date): ________________ ❑ Referred to (profession and date): ______________ ❑ Client will:	
(2) ❑ No ❑ Yes. Explain how long and how often:	Update:	
(3) ❑ No ❑ Yes. Explain how long and how often:	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	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:	
(2) Are there any changes to food choices noted above? ❑ No ❑ Yes. Explain:	Update:	
(3) Are there any changes to food choices noted above? ❑ No ❑ Yes. Explain:	Update:	

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 2 Complete Nutrition Assessment ❑ 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:	

Client Identifier

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