

**FORWARDHEALTH
 CHILD CARE COORDINATION
 FAMILY QUESTIONNAIRE**

Instructions: Type or print clearly. Refer to the Family Questionnaire Completion Instructions, F-1118A. Refer to the key at the end of the form for symbol descriptions. Elements in **bold** indicate initial screen questions.

SECTION I — GENERAL INFORMATION

1. Name — Mother (Last, First, Middle Initial)	2. Address — Mother (Street, City, State, and ZIP Code)
3. Date of Birth — Mother	4. Age — Mother < 18 years = (70) 18-20 years = (15)
5. Mother's Member Identification Number	6. Telephone Number — Home <input type="checkbox"/> No telephone or telephone is often disconnected = (15)
7. How can we contact you?	
8. Are other agency staff visiting your home? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list if known.	
9. Name — Infant	10. Gender — Infant <input type="checkbox"/> Female <input type="checkbox"/> Male
11. Birth Weight If very low birth weight < 3.3 lbs. (1500 grams) = (70) If low birth weight < 5.5 lbs. (2500 grams) = (30) If birth weight > 10 lbs. (4540 grams) = (10)	12. Date of Birth If pre-term (gestational age < 37 weeks) = (70)
13. Name — HMO	14. Name — Primary Care Doctor / Clinic If none or unable to answer = (10)

SECTION II — EMPLOYMENT

1. Are you employed? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what is your occupation?	2. If you are employed, how many hours do you usually work in a week?
3. What shift? (Days, Evenings, Nights)	4. Do you feel your child care arrangements are safe and nurturing? <input type="checkbox"/> No = (15) <input type="checkbox"/> Yes
5. If returning to work / school, when will you go back?	6. What was the last grade you finished? 8 th grade or less = (40) > 8 th grade but < 12 th grade = (15)
7. What are your sources of income? (Check all that apply.) <input type="checkbox"/> Parents <input type="checkbox"/> Job <input type="checkbox"/> Partner / Spouse ts <input type="checkbox"/> Unemployment Benefits <input type="checkbox"/> Child Support Payments <input type="checkbox"/> Other _____	

Points (Subtotal) _____

Continued

SECTION III — FAMILY FUNCTIONING

<p>1. Are you married or single?</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Single (Includes Never Married, Separated, Divorced, Widowed)</p>	<p>2. Do you speak English?</p> <p><input type="checkbox"/> Very well</p> <p><input type="checkbox"/> A little = (10)</p> <p><input type="checkbox"/> Not at all = (15)</p>
<p>3. Do you read English?</p> <p><input type="checkbox"/> Very well</p> <p><input type="checkbox"/> A little = (10)</p> <p><input type="checkbox"/> Not at all = (15)</p>	<p>4. If of school age now, are you enrolled and do you attend school regularly?</p> <p><input type="checkbox"/> No = (10)</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> I am working on GED or have completed it</p> <p><input type="checkbox"/> I have dropped out = (10)</p>
<p>5. Have you in the past, or are you currently, receiving special or exceptional education services?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes = (10)</p>	<p>6. How many children do you have?</p> <p style="text-align: right;">If first child = (10)</p> <p style="text-align: right;">If > 4 children = (40)</p> <p style="text-align: right;">If > 2 children and mother is < 18 = (40)</p>
<p>7. Within the last 12 months, have any of your children been taken away from you?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes = (40)</p> <p>If yes, how many? _____</p>	<p>8. Where do you live?</p> <p><input type="checkbox"/> House / Mobile Home</p> <p><input type="checkbox"/> Apartment Mobile Home</p> <p><input type="checkbox"/> With friends = (10)</p> <p><input type="checkbox"/> With other family members = (10)</p> <p><input type="checkbox"/> Homeless (including shelter, hotel / motel) = (70)</p> <p><input type="checkbox"/> Other (Specify) _____</p>
<p>9. Who is currently living in your home? (Name, Age, Relationship)</p>	<p>10. Where you live now, do you have the following?</p> <p>Running water? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hot water? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Working appliances (stove, refrigerator)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Working bathroom / bathing facilities? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Working smoke detector? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Working fire extinguisher? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Each "No" = (5) Total points _____</p>
<p>11. Is there chipping paint inside / outside your home?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes = (10)</p>	<p>12. How many times have you moved in the last year?</p> <p style="text-align: right;">> 2 times = (20)</p>
<p>13. Do you think you will need to move in the next 12 months?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>14. How long have you been living in the present neighborhood?</p>
<p>15. What do you think of your neighborhood?</p> <p><input type="checkbox"/> It's a good place to live.</p> <p><input type="checkbox"/> It's an okay place to live.</p> <p><input type="checkbox"/> It's a bad place to live.</p>	<p>16. What is the best thing about your neighborhood?</p>
<p>17. What is the worst thing about your neighborhood?</p>	<p>18. In the past two years, has your neighborhood become</p> <p><input type="checkbox"/> A better place to live.</p> <p><input type="checkbox"/> Stayed the same.</p> <p><input type="checkbox"/> A bad place to live.</p>

Points (Subtotal) _____

Continued

SECTION III — FAMILY FUNCTIONING (Continued)

19. Do your children have a safe play area both inside and outside the home?

- No = **(5)**
- Yes

20. If not at home, where else can they play? (Check all that apply.)

- Relatives
- Park
- Community Center
- Nowhere = **(15)**
- School Playground
- Other

21. Have you witnessed acts of violence in your neighborhood? (If so, describe these acts and the impressions they had on you.)

22. Does your family own an automobile?

- No
- Yes

23. If yes, what is the condition of the automobile?

- Good
- Average
- Below Average

24. If you do not have an automobile, how do you get around?

- Get a ride from friends / relatives
- Use public transportation
- Walk
- Other _____

25. How often do you have problems getting transportation?

- Never
- Occasionally
- Most of the time = **(10)**

26. If you use a car, does everyone use car seats or seat belts?

- Always
- Sometimes
- Never = **(5)**
Explain

SECTION IV — HEALTH

1. Where do you go for your regular health care (e.g., checkups, shots)?

- Family Doctor / Primary Care Provider / Clinic
- Emergency Room
- Other

2. Have any of your children been hospitalized in the past six months?

- No
- Yes = **(10)**
If yes, for what type of problem(s)?

3. Have your children between 6 months and 6 years of age been tested for lead poisoning?

- No = **(5)**
- Yes
- Don't know = **(5)**
- Not applicable (Skip to Element 6)

4. If yes, have you received the results?

- No = **(5)**
- Yes

5. If the results require follow-up, has this occurred?

- No = **(5)**
- Yes

6. Do you have a record of your child's immunizations?

- No = **(5)**
- Yes

Points (Subtotal) _____

Continued

SECTION IV — HEALTH (Continued)

<p>7. If your child(ren) are 3 years or older, are they seeing a dentist?</p> <p><input type="checkbox"/> No = (5) <input type="checkbox"/> Yes <input type="checkbox"/> Not applicable</p>	<p>8. How many months pregnant were you when you started seeing a medical provider (doctor, nurse practitioner, nurse midwife) for prenatal care?</p> <p>_____ weeks or _____ months</p> <p>13-15 weeks = (5) 15-23 weeks = (10) > 24 weeks = (20)</p>
<p>9. Did you receive prenatal care coordination services during this pregnancy?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes = (70)</p>	<p>10. How was your health during this pregnancy?</p> <p><input type="checkbox"/> Fine, no problems <input type="checkbox"/> Some problems (e.g., nausea, tiredness) <input type="checkbox"/> Serious problems (e.g., high blood pressure, diabetes) = (10) Explain:</p>
<p>11. Did your baby stay in a “special care” nursery for more than one day?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes = (10) If yes, how many?</p>	<p>12. Which of the following was your pregnancy?</p> <p><input type="checkbox"/> Planned <input type="checkbox"/> Unplanned = (5) <input type="checkbox"/> Result of sexual assault = (40)</p>
<p>13. How do you feel now that the baby is born?</p> <p><input type="checkbox"/> Happy <input type="checkbox"/> Unsure — a little bit happy, a little bit unhappy = (10) <input type="checkbox"/> Very upset about it = (20)</p>	<p>14. How does the father of the baby (or your partner) feel about the newborn?</p> <p><input type="checkbox"/> Happy <input type="checkbox"/> Unsure — a little bit happy, a little bit unhappy = (10) <input type="checkbox"/> Very upset about it = (20)</p>
<p>15. Do you have any history of prenatal or postpartum depression, raging, or “scary” thoughts about the baby?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes = (40)</p>	<p>16. Do you plan to have another baby?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how soon?</p>
<p>17. Are you currently using birth control?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>18. Do you understand how to use the product?</p> <p><input type="checkbox"/> No = (5) <input type="checkbox"/> Yes</p>
<p>19. Have you experienced any problems getting the necessary supplies, medication, or services?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes = (5)</p>	<p>20. Do you or your children receive Supplemental Security Income (SSI) benefits or special services for a health problem?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes = (20) If yes, who?</p> <p>What services?</p> <p>If receiving mental health-related services = (50)</p>
<p>21. Are your children in a Women, Infants, and Children Supplemental Nutrition Program (WIC)</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes If yes, where?</p>	<p>22. How are you currently feeding your baby?</p> <p><input type="checkbox"/> Breast feed <input type="checkbox"/> Bottle feed <input type="checkbox"/> Both breast and bottle</p>

Points (Subtotal) _____

Continued

SECTION IV — HEALTH (Continued)

23. At what age do you plan to start feeding cereal / baby food to your new baby?

- Birth-3 months = (5)
- 4-6 months
- I don't know = (5)

24. Are any of your children on a special diet or receiving special foods or drinks?

- No
- Yes = (5)
If yes, what?

25. Do you or your children ever eat non-food items (e.g., dirt, sand, starch, paint chips)?

- No
- Yes = (20)

26. Do you sometimes run out of food before you are able to buy more?

- No
- Yes = (10)

SECTION V — PARENTING ATTITUDES / SKILLS

1. How do you feel about the way you were raised as a child?

- Very positive; I had a happy childhood; my parents were very caring.
- Okay; my parents tried to do their best; my parents were caring.
- Negative; I received no nurturing = (10)
- Very negative; I was punished frequently and received little or no nurturing = (40)

2. If you plan to parent differently than you were raised, how much support / encouragement will you get from your family / friends?

- A lot
- A little
- Very little = (10)
- None = (20)

3. When you want advice about parenting, who do you go to? (Check all that apply.)

- | | | |
|--|--|--|
| <input type="checkbox"/> Parents | <input type="checkbox"/> Friends | <input type="checkbox"/> Doctor / Nurse |
| <input type="checkbox"/> Community "Helping Organizations" | <input type="checkbox"/> I Don't Have Anyone to Ask = (10) | <input type="checkbox"/> "It Comes Naturally" = (10) |
| <input type="checkbox"/> Grandparents / Family | <input type="checkbox"/> Father of the Child / Partner | <input type="checkbox"/> Books / Magazines |

4. Do you ever feel your infant cries or is demanding "on purpose" or just to irritate you?

- No
- Yes = (40)
If yes, explain.

5. At what age do you think your baby will do the following?

- Be potty trained
- Sleep all night
- Begin to walk

If answer is unrealistic = (15)

6. Do you have an adequate supply or access to toys, books, games, or other play equipment?

- No
- Yes

7. When your children are playing or having fun, do you join them?

- Most of the time
- Occasionally = (5)
- Rarely = (10)

8. How helpful is the child's father (or your partner) in raising this child and other children in your household?

- Very helpful
- Helps when requested to help
- Not helpful = (10)

9. Finish this sentence.

I think my / our children are ...

Use of strong negatives, such as "interfere with my activities," "too demanding," "too much work," "ugly," "stupid," "bad" = (20)

Points (Subtotal) _____

Continued

SECTION VI — TOBACCO, ALCOHOL, AND OTHER DRUGS

1. Do you or anyone else in your household smoke?

- No
- Yes

2. If yes, do you have "rules" governing when and where not to smoke?

- No = **(20)**
- Yes

I need to ask you a few questions about drinking and drug use. It will help us take better care of you and your children. Be sure to include beer, wine, and liquor in your answers to the following questions.

3. How many drinks does it take to make you feel high?

> 2 = **(20)**

- I never drink

4. How much can you hold?

> 2 = **(20)**

- I never drink
- I don't know

5. Have people annoyed you by criticizing your drinking?

- No
- Yes = **(20)**
- I never drink

6. Have you ever felt you ought to cut down on your drinking?

- No
- Yes = **(20)**
- I never drink

7. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

- No
- Yes = **(20)**
- I never drink

8. **In the past 12 months, have you injected a non-prescribed drug or used any other street drugs (e.g., marijuana, hash, cocaine, heroin, crack, amphetamines)?**

- No
- Yes = **(70)**

9. **Does anyone who is involved in caring for your children abuse alcohol or other drugs?**

- No
- Yes = **(20)**
If yes, explain.

SECTION VII — PERSONAL SUPPORT / COPING SKILLS

1. **How do you deal with stress and anger?** (Check all that apply.)

- Talk it out
- Calm down by taking a walk, doing some activity
- Not talk about it at all = **(5)**
- Take it out on somebody by yelling = **(5)**
- Get violent (e.g., hitting, threatening with object or weapon) = **(50)**
- Have a drink or get high to calm my nerves = **(20)**
- Other _____

2. **How does the father of the baby (or your partner) deal with stress and anger?** (Check all that apply.)

- Talk it out
- Calm down by taking a walk, doing some activity
- Not talk about it at all = **(5)**
- Take it out on somebody by yelling = **(5)**
- Get violent (e.g., hitting, threatening with object or weapon) = **(50)**
- Have a drink or get high to calm my nerves = **(20)**
- Other _____

Points (Subtotal) _____

Continued

SECTION VII — PERSONAL SUPPORT / COPING SKILLS (Continued)

<p>3. Have you or your children ever been emotionally or verbally abused by the father of the baby, your partner, or someone close to you?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes = (70)</p>	<p>4. Does the father of the baby (or your partner) physically, verbally, or emotionally abuse you or your children?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes = (70)</p>
<p>5. Have you or other household members been raped or forced to have sex against your / their will?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes = (30)</p>	<p>6. Does the abuser(s) still have access to you or your children?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes = (40)</p>
<p>7. Has anyone in your immediate household (parent, spouse, partner, sibling) been incarcerated / jailed for a crime in the past year or more than three times in the past five years?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes = (40)</p>	<p>8. Are you afraid of the father of the baby, your partner, or anyone else in your household?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes = (20)</p>
<p>9. Is there a gun in your home?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes = (10)</p>	<p>10. If yes, are the guns unloaded and stored in a locked place?</p> <p><input type="checkbox"/> No = (15) <input type="checkbox"/> Yes</p>
<p>11. How many people do you know well enough to visit with in your neighborhood?</p> <p><input type="checkbox"/> None = (5)</p>	<p>12. How often do you spend time with friends or relatives?</p> <p><input type="checkbox"/> Never = (10)</p>
<p>13. Do you have someone you can talk with when you need to?</p> <p><input type="checkbox"/> No = (20) <input type="checkbox"/> Yes</p>	<p>14. Do you find yourself feeling lonely?</p> <p><input type="checkbox"/> Quite often <input type="checkbox"/> Sometimes <input type="checkbox"/> Almost never</p>
<p>15. Is there anyone you can count on in case of an emergency?</p> <p><input type="checkbox"/> No = (10) <input type="checkbox"/> Yes</p>	<p>16. Is there someone who could help you for as long as you needed their help?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>
<p>17. Are you known or do you think of yourself as a resource to others?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>18. How often do you go to neighborhood activities such as spiritual ceremonies, support groups, or "club" functions?</p> <p><input type="checkbox"/> Never = (5)</p>
<p>19. How would you describe yourself to someone who does not know you?</p>	
<p>20. Does your family have special traditions that they observe?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes If yes, explain.</p>	
<p>21. Tell me about your family's strengths.</p> <p><input type="checkbox"/> None = (10)</p>	

Points (Subtotal) _____

Continued

SECTION VII — PERSONAL SUPPORT / COPING SKILLS (Continued)

22. Which of these things worry you a lot? (Check all that apply.)

- Money problems = (2)
- Transportation = (2)
- My job = (2)
- My partner's job or unemployment = (2)
- Caring for this baby / my other children = (2)
- Housing problems / getting evicted = (2)
- Getting child care = (2)
- My physical or mental health / safety = (2)
- My drinking / drug use = (2)
- My relationship with my partner = (2)
- My child's relationship with his / her father = (2)
- My partner is in jail = (2)

23. Would you like help or information with any of these things?

- Discipline
- Child development
- Parenting skills
- Playing with your children
- Health issues
- Employment training
- Coping with stress
- Family planning / pregnancy prevention
- Community resources for parents

SECTION VIII — SIGNATURES

SIGNATURE — STAFF

Assessment Date

SIGNATURE — STAFF

Reassessment Date

Points (Subtotal) _____

Total Points (All Pages) _____

Key:

> = Greater Than

< = Less Than