COMPREHENSIVE PERINATAL SERVICES PROGRAM

Prenatal Combined Assessment / Reassessment Tool

Initial _____/_____ (1st OB) Date Weeks 2nd Trimester _____/_____ (14-27 weeks) Date Weeks 3rd Trimester _____/_____ (28 weeks-Delivery) Date Weeks

This Prenatal Combined Assessment /Reassessment Tool has received California State Department of Health Services approval and **MAY NOT BE ALTERED** except to be printed on your logo stationery.

Patient Name:_____ Date Of Birth:_____

Health Plan:_____ Identification No.: _____

Provider:_____ Hospital: _____ Location: _____

Case Coordinator/Manager:_____ EDC: _____

Dx. OB High Risk Condition:_____

Personal Information

1. Patient age: ☐ Less than 12 years ☐ 12-17 years ☐ 18-34 years ☐ 35 years or older
2. Are you: ☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed ☐ Other: _____
3. How long have you lived in this area? _____ yrs./mos. Place of birth: _____
4. Do you plan to stay in this area for the rest of your pregnancy? ☐ Yes ☐ No
5. Years of education completed: ☐ 0-8 years ☐ 9-11 years ☐ 12-16 years ☐ 16+ years
6. What language do you prefer to speak: ☐ English ☐ Spanish ☐ Other: _____
7. What language do you prefer to read: ☐ English ☐ Spanish ☐ Other: _____
8. Which of the following best describes how you read:
   ☐ Like to read and read often ☐ Can read, but read slowly or not very often ☐ Do not read
9. Father of baby: (name) _____ His preferred language: _____ Education: _____ Age: _____
10. Was this a planned pregnancy? ☐ Yes ☐ No
11. How do you feel about being pregnant now?
    0-13 wks: ☐ Good ☐ Troubled, please explain: _____
    14-27 wks: ☐ Good ☐ Troubled, please explain: _____
    28-40 wks: ☐ Good ☐ Troubled, please explain: _____
12. Are you considering (circle)adoption/abortion? ☐ No ☐ If Yes, Do you need information/referrals? ○ No ○ Yes
13. How does the father of the baby feel about this pregnancy? _____
    Your family? _____
    Your friends? _____

Economic Resources

14. a) Are you currently working or going to school? ☐ Yes - type & hr/week: _____ Cal Learn? ☐ Yes ☐ No
b) Do you plan to work or go to school while you are pregnant? ☐ Yes - type: _____ How long?____ ☐ No
c) Do you plan to return to work or go to school after the baby is born? ☐ Yes type: _____ ☐ No

15. Will the father of the baby provide financial support to you and/or the baby? ☐ Yes ☐ No
Other sources of financial help? _____

16. Are you receiving any of the following? (check all that apply)

	0-13 wks:		14-27 wks:		28-40 wks:		Referral Date
	Yes	No	Yes	No	Yes	No	
a. WIC	☐	☐	☐	☐	☐	☐	
b. Food Stamps	☐	☐	☐	☐	☐	☐	
c. AFDC/TANF	☐	☐	☐	☐	☐	☐	
d. Emergency Food Assistance	☐	☐	☐	☐	☐	☐	
e. Pregnancy-related disability insurance benefits	☐	☐	☐	☐	☐	☐	
f. Other:_____	☐	☐	☐	☐	☐	☐	

17. Do you have enough of the following for yourself and your family?

	0-13 wks:		14-27 wks:		28-40 wks:	
	Yes	No	Yes	No	Yes	No
Clothes	☐	☐	☐	☐	☐	☐
Food	☐	☐	☐	☐	☐	☐

Housing

18. What type of housing do you currently live in? ☐ House ☐ Apartment ☐ Trailer Park ☐ Public Housing
☐ Hotel/Motel ☐ Farm Worker Camp ☐ Emergency Shelter ☐ Car ☐ Other: _____
Any Changes? ☐ No ☐ Yes 14-27 wks: _____ ☐ No ☐ Yes 28-40 wks: _____

19. Do you have the following where you live? ↙ ☐ Yes 0-13 wks ☐ Yes 14-27 wks ☐ Yes 28-40 wks

0-13 wks:	**No:** ☐ toilet	☐ stove/place to cook ↙	☐ tub/shower	☐ electricity	☐ refrig. ↙	☐ hot/cold water	☐ phone
14-27 wks:	**No:** ☐ toilet	☐ stove/place to cook ↙	☐ tub/shower	☐ electricity	☐ refrig. ↙	☐ hot/cold water	☐ phone
28-40 wks:	**No:** ☐ toilet	☐ stove/place to cook ↙	☐ tub/shower	☐ electricity	☐ refrig. ↙	☐ hot/cold water	☐ phone

20. Do you feel your current housing is adequate for you? ☐ Yes ☐ No, please explain: _____

21. Do you feel your home is safe for you and your children? ☐ Yes 0-13 wks ☐ Yes 14-27 wks ☐ Yes 28-40 wks
☐ No 0-13 wks, please explain: _____
☐ No 14-27 wks, please explain: _____
☐ No 28-40 wks, please explain: _____

22. If there are guns in your home, how are they stored? _____ ☐ N/A

23. Do any of your children or your partner's children live with someone else? ☐ N/A ☐ No
☐ If Yes, please explain: _____

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Transportation

24. Will you have problems keeping your appointments/attending classes? ☐ No 0-13 wks: ☐ No 14-27 wks: ☐ No 28-40 wks:

☐ Yes 0-13 wks: ☐ Transportation ☐ Child care ☐ Work ☐ School ☐ Other: _____
☐ Yes 14-27 wks: ☐ Transportation ☐ Child care ☐ Work ☐ School ☐ Other: _____
☐ Yes 28-40 wks: ☐ Transportation ☐ Child care ☐ Work ☐ School ☐ Other: _____

25. When you ride in a car, do you use seatbelts? ☐ Never ☐ Sometimes ☐ Always

26. Do you have a car seat for the new baby?
0-13 weeks: ☐ Yes ☐ No 14-27 weeks: ☐ Yes ☐ No 28-40 weeks: ☐ Yes ☐ No

27. How will you get to the hospital? 14-27 weeks: _____ 28-40 weeks: _____

Current Health Practices

28. Do you know how to find a doctor for you and your family? ☐ Yes ☐ No, explain: _____

29. Do you have a doctor for your baby? 14-27 wks: ☐ Yes ☐ No 28-40 wks: ☐ Yes ☐ No Who? _____

30. Have you been to a dentist in the last year? ☐ Yes ☐ No Any dental problems? ☐ No ☐ Yes, please describe:

31. On average, how many total hours at night do you sleep? 0-13 wks: _____ 14-27 wks: _____ 28-40 wks: _____
On average, how many total hours do you nap in the day? 0-13 wks: _____ 14-27 wks: _____ 28-40 wks: _____

32. Do you exercise? ☐ No ☐ Yes, what kind? _____ how often? minutes/day _____ days/week ___

33. Are you smoking/using chewing tobacco now? ↙ ☐ No 0-13 wks ☐ No 14-27 wks ☐ No 28-40 wks

0-13 wks: ☐ If Yes, for how many years? _____ how much per day? _____ Have you tried to quit? ☐ Yes ☐ No
14-27 wks: ☐ If Yes, how much per day? _____ have you tried to quit during this pregnancy? ☐ Yes ☐ No
28-40 wks: ☐ If Yes, how much per day? _____ have you tried to quit during this pregnancy? ☐ Yes ☐ No

34. Are you exposed to second-hand smoke? ↙ at home? ☐ No ☐ Yes at work? ☐ No ☐ Yes

35. Do you handle or have exposure to chemicals? (examples: glue, bleach, ammonia, pesticides, fertilizers, cleaning solvents, etc.)

0-13 wks: (circle) At work - home - hobbies? ☐ No ☐ Yes, _____
14-27 wks: (circle) At work - home - hobbies? ☐ No ☐ Yes, _____
28-40 wks: (circle) At work - home - hobbies? ☐ No ☐ Yes, _____

36. In your home, how do you store the following?
☐ Vitamins: _____
☐ Medications: _____ ☐ Cleaning agents: _____

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37. Are you taking any prescription, over-the-counter, herbal or street drugs? ↙

☐ None 0-13 weeks ☐ None 14-27 weeks ☐ None 29-40 weeks

Examples: Tylenol→, Tums→, Sudafed→, laxatives, appetite suppressants, aspirin, prenatal vitamins, iron, allergy medications, Aldomet→, Prozac→, ginseng, manzanilla, greta, magnesium, yerba buena, marijuana, cocaine, PCP, crack, speed, crank, ice, heroin, LSD, other?

☐ Yes, 0-13 weeks: _____

☐ Yes, 14-27 weeks: _____

☐ Yes, 28-40 weeks: _____

38. How much of the following do you drink per day? ↙ ____ Water ____ Milk ____ Juice ____ Decaf Coffee

____ Coffee ____ Punch, Kool-Aid, Tang ____ Soda ____ Diet Soda ____ Herb tea

____ Beer ____ Wine ____ Wine Coolers ____ Hard Liquor ____ Mixed Drinks

14-27 wks: Has this changed? ☐ No ☐ Yes, how? _____

28-40 wks: Has this changed? ☐ No ☐ Yes, how? _____

39. If you use drugs and/or alcohol, are you interested in quitting? ☐ Yes ☐ No

Have you tried to quit? ☐ Yes ☐ No comments: _____

Pregnancy Care

40. Besides having a healthy baby, what are your goals for this pregnancy? _____

41. Do you plan to have someone with you:

	14-27 weeks:			28-40 weeks:		
During labor?	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure
When you first come home with the baby?	☐ Yes	☐ No	☐ Unsure	☐ Yes	☐ No	☐ Unsure

42. If you had a baby before, where was that baby(ies) delivered? ☐ N/A ☐ Hospital ☐ Clinic ☐ Home

☐ Other: _____ Were there any problems? ☐ No ☐ Yes, please explain: _____

43. Have you lost any children? ☐ No ☐ If Yes, please explain: _____

44. Do you have any traditions, customs or religious beliefs about pregnancy? ☐ No ☐ If Yes, please explain: _____

45 Does the doctor say there are any problems with this pregnancy?

14-27 wks: ☐ No ☐ Yes please describe: _____

28-40 wks: ☐ No ☐ Yes please describe: _____

46. Are you scheduled for any tests?

14-27 wks: ☐ No ☐ If Yes, what: _____

28-40 wks: ☐ No ☐ If Yes, what: _____

Do you have any questions? ☐ No ☐ If Yes, what: _____

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47. Have you experienced any of the following discomforts during this pregnancy?

If Yes, check box:	0-13 wks:	14-27 wks:	28-40 wks:
Edema (swelling of hands or feet) ↙	☐	☐	☐
Diarrhea ↙	☐	☐	☐
Constipation ↙	☐	☐	☐
Nausea/vomiting ↙	☐	☐	☐
Leg cramps ↙	☐	☐	☐
Hemorrhoids	☐	☐	☐
Heartburn	☐	☐	☐
Vaginal Bleeding	☐	☐	☐
Varicose veins	☐	☐	☐
Headaches	☐	☐	☐
Backaches	☐	☐	☐
Abdominal cramping/contractions	☐	☐	☐
Other: _____		Other: _____	Other: _____

48. In comparison to your previous pregnancies, is there anything you would like to change about the care you receive this time?
☐ N/A ☐ No ☐ If Yes, please explain: _____

49. Who has given you the most advice about your pregnancy? _____

50. What are the most important things they have told you? _____

51. Are you planning to use birth control after this pregnancy?

14-27 wks: ☐ No ☐ Undecided If Yes, ☐ what method?

(circle) Birth control pills Diaphragm Norplant IUD Abstinence
Foam and/or condoms Natural family planning Tubal/Vasectomy Depoprovera

28-40 wks: ☐ No ☐ Undecided If Yes, ☐ what method?

(circle) Birth control pills Diaphragm Norplant IUD Abstinence
Foam and/or condoms Natural family planning Tubal/Vasectomy Depoprovera

52. Your current or past behaviors, or the current or past behaviors of your sexual partner(s) may place you at risk for being / becoming infected with HIV, the virus which causes AIDS. Since 1979 have you or any of your sexual partner(s):

(check all that apply)	self	partner(s)	unknown	no
Had sex with more than one partner?				
Had sex with someone you/they didn't know well?				
Been treated for trichomonas, chlamydia, genital warts, syphilis, gonorrhea, or other sexually transmitted infections?				
Had sex with someone who used drugs?				
Had hepatitis B?				
Shared needles?				
Had a blood transfusion since1979?				

Is there any other reason you think you might be at risk for HIV/AIDS? ☐ No ☐ If Yes, please explain: _____

_____

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Change in HIV risk status? 14-27 weeks: ☐ No ☐ Yes, what? _____

28-40 weeks: ☐ No ☐ Yes, what? _____

53. Have you been offered counseling/information on the benefits of HIV testing and been offered a blood test for HIV?

0-13 wks: ☐ No (Refer to OB provider)

14-27 wks: ☐ No (Not applicable if previous Yes answer)

28-40 wks: ☐ No (Not applicable if previous Yes answer)

☐ If Yes, do you have any questions? _____

Educational Interests

54. If you have had experience or received education/information in any of the following topics check Column A. If would you like more information check Column B.

TOPIC	0-13 WKS		14-27 WKS		28-40 WKS		Educational Materials Provided		
	A	B	A	B	A	B	Date	Code*	Initials
How your baby grows (fetal development)									
How your body changes during pregnancy									
Healthy habits for a healthy pregnancy/baby									
Assistance with cutting down/quitting smoking									
Assistance with cutting down/quitting alcohol or drugs									
What happens during labor and delivery									
Hospital Tour									
Helping your child(ren) get ready for a new baby									
How to take care of yourself after the baby comes									
Breastfeeding									
How to take care of your baby/infant safety									
Infant development									
How to avoid sexually transmitted infections/HIV									
Circumcision									

* Teaching Codes: A = Answered questions E = Explained verbally V = Video shown
W = Written material provided S = Visual aids shown I = Interpreter used

55. Is there anything special you would like to learn? ☐ No ☐ Yes, what? _____

56. How do you like to learn new things? ☐ Read ☐ Talk one-on-one ☐ Group education/classes
☐ Watch a Video ☐ Pictures and diagrams ☐ Being shown how to do it
☐ Other: _____

57. Will someone be able to attend classes with you? ☐ No ☐ Yes, who? _____

58. Do you have any physical, mental, or emotional conditions, such as learning disabilities, Attention Deficit Disorder, depression, hearing or vision problems that may affect the way you learn? ☐ No ☐ Yes: _____

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Nutrition - A copy of this page should be sent with the client to WIC **Date:**_____

Anthropometric: EDC: _____ WKS GA: _____ Height: _____ Current weight : _____

59. Weight gain in previous pregnancies: 1st: _____ ☐ Unknown 2nd: _____ ☐ Unknown ☐ N/A

Recommended weight gain during pregnancy (check one)

60. Prepregnant weight: _____ lbs. ☐ for underweight women 28-40 lbs. ☐ for normal weight women 25-35 lbs.

61. Net weight gain: _____ lbs. ☐ for overweight women 15-25 lbs ☐ for very overweight women 15-20 lbs

☐ Adequate ☐ Inadequate ☐ Excessive ☐ Weight loss ☐ Weight grid plotted

Biochemical Data:

62. Urine-Date: _____ (circle + or -) Glucose: + - Ketones: + - Protein: + -

63. Blood-Date drawn: _____ Hgb: _____ (<10.5) Hct: _____ (< 32) MCV: _____ Glucose: _____

Clinical Data:

64. ☐ None relevant 65. ☐ Age 17 or less (#1) 66. ☐ Pregnancy interval < 1 yr.

67. ☐ High Parity (≥4 births) 68. ☐ Multiple Gestation 69. ☐ Currently Breastfeeding

70. ☐ Dental Problems (#30) 71. ☐ Serious Infections 72. ☐ Anemia

73. ☐ Diabetes (circle) Prepreg Past preg Current preg comments: _____

74. ☐ Hypertension (circle) Prepreg Past preg Current preg comments: _____

75. ☐ Hx. of poor pregnancy outcome (e.g., preterm delivery, fetal/neonatal loss): _____

76. ☐ Other medical/obstetrical problems (low birth weight, large for gest. age, PIH): Past: _____

Present: _____

77. Psychosocial or Health Education Problems: ☐ Eating disorder ☐ Psychiatric illness (#99) ☐ Abuse (# 102-106)

☐ Homelessness (#18) ☐ Dev. disability (#58) ☐ Low education (#5) ☐ Other: _____

Dietary:

78. Any discomforts? (#47) ☐ No ☐ If Yes, please check: ☐ Nausea ☐ Vomiting ☐ Swelling ☐ Diarrhea ☐ Constipation ☐ Leg cramps ☐ Other: _____

79. Do you ever crave/eat any of the following? ☐ No, ☐ If Yes, please check ☐ Dirt ☐ Paint chips ☐ Clay ☐ Ice ☐ Paste ☐ Freezer Frost ☐ Cornstarch ☐ Laundry starch ☐ Plaster ☐ Other: _____

80. a) Number of meals/day : _____ b) meals often skipped? ☐ No ☐ Yes c) Number of snacks/day : _____

81. Who does the following in your home: a) buys food: _____ b) prepares food : _____

82. Do you have the following in your home: (#19) a) stove/place to cook? ☐ No ☐ Yes b) refrigerator? ☐ No ☐

83. Are you on any special diet? ☐ No ☐ If yes, please explain: _____

84. a) Any food allergies? ☐ No ☐ If yes, please explain: _____

b) Any foods/beverages you avoid? ☐ No ☐ If yes, please explain: _____

85. Are you a vegetarian? ☐ No ☐ If Yes, do you eat: ☐ Milk Products ☐ Eggs ☐ Nuts ☐ Dried Beans ☐ Chicken/Fish

86. Substance use? ☐ No ☐ Alcohol (#38) ☐ Drugs (#37) ☐ Tobacco (#33) ☐ Secondhand smoke (# 34)

☐ Present: _____ ☐ Past: _____

87. Currently use? (#37) ☐ None ☐ Prenatal vitamins ☐ Iron pills ☐ Other _____

☐ Herbal remedies: _____ ☐ Antacids ☐ Laxatives ☐ Other medicines: _____

88. Any previous breastfeeding experience? ☐ N/A ☐ No ☐ If Yes, how long? _____ ☐ < 1 month

Why did you stop? _____

89. Current infant feeding plans: ☐ Breast ☐ Breast & Formula ☐ Formula ☐ Undecided

90. **Nutrition Assessment Summary** ☐ 24 hour recall ☐ Food frequency (7 days)

a) **Food Group**	Servings/ Points	Suggested Changes		**Food Group**	Servings/ Points	Suggested Changes	
Protein		+ -		Vit. A-rich fruit/veg		+ -	
Milk products		+ -		Other fruit/veg		+ -	
Breads/cereals/grains		+ -		Fats/Sweets		+ -	
Vit. C-rich fruit/veg		+ -					

☐ **Referred to Registered Dietitian**

b) Diet adequate as assessed: ☐ Yes ☐ No **c) Excessive** ☐ Caffeine (#38)

Completed by: _____

Title: _____ Minutes: _____

Facility: _____ Telephone: _____

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GROUP	FOOD	POINTS NEEDED	SERVINGS/DAY	MAJOR NUTRIENTS
1	PROTEINS	21	3	PROTEIN, IRON, ZINC
2	MILK	21	3	CALCIUM, PROTEIN, VITAMIN D
3	BREADS, GRAINS	49	7	CARBOHYDRATES, B VITAMINS, IRON
4	FRUITS/VEGETABLES	7	1	VITAMIN C, FOLIC ACID
5	FRUITS/VEGETABLES	7	1	VITAMIN A, FOLIC ACID
6	FRUITS/VEGETABLES	21	3	CONTRIBUTES TO INTAKE OF VITAMINS A & C
OTHER	FATS AND SWEETS	N/A	3	VITAMIN E

Refer to Protocols for instructions on completing the dietary assessment using the point system above.

90. **(continued)**

14-27 weeks:

a) **Food Group**	**Servings/ Points**	**Suggested Changes**			
Protein		+	-		
Milk products		+	-		
Breads/cereals/grains		+	-		
Vit. C-rich fruit/veg		+	-		
Vit. A-rich fruit/veg		+	-		
Other fruit/veg		+	-		
Fats/Sweets		+	-		

b) **Diet adequate as assessed**: ☐ Yes ☐ No

c) **Excessive:** ☐ Caffeine (#38) ☐ Referred to Registered Dietitian

28-40 weeks:

a) **Food Group**	**Servings/ Points**	**Suggested Changes**			
Protein		+	-		
Milk products		+	-		
Breads/cereals/grains		+	-		
Vit. C-rich fruit/veg		+	-		
Vit. A-rich fruit/veg		+	-		
Other fruit/veg		+	-		
Fats/Sweets		+	-		

b) **Diet Adequate as assessed:** ☐ Yes ☐ No

c) **Excessive:** ☐ Caffeine (#38) ☐ Referred to Registered Dietitian

14-27 weeks: **Date:** _____

Anthropometric: BP: _____ **Biochemical:**

Weight: _____ Urine: Glucose: - +

Net wt. gain: _____ (61) Protein: - +

☐ Adequate Ketones: - +

☐ Inadequate Blood drawn: date: _____

☐ Excessive Hgb: ___ Hct: ___ MCV: ___

28-40 weeks: **Date:** _____

Anthropometric: BP: _____ **Biochemical:**

Weight: _____ Urine: Glucose: - +

Net wt. _____ (61) Protein: - +

☐ Adequate Ketones: - +

☐ Inadequate Blood drawn: date: _____

☐ Excessive Glucose____ Hgb: ___ Hct: ___ MCV: ___

91. ☐ 3 Hr GTT: Fasting: _____ 1 Hr: _____ 2 Hr: _____ 3 Hr: _____ ☐ N/A (1 Hr < 140 dl/ml.)

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92. Are you on any special diet? 14-27 weeks: ☐ No ☐ If Yes, please explain: _____
28-40 weeks: ☐ No ☐ If Yes, please explain: _____

93. Have your eating habits changed since you've been pregnant?
14-27 wks: ☐ No ☐ If Yes, how: ☐ Eat more: ○ Vegetables ○ Fruit ○ Protein ○ Milk ○ Bread ○ Other: _____
☐ Eat less: ○ Vegetables ○ Fruit ○ Protein ○ Milk ○ Bread ○ Other: _____
28-40 wks: ☐ No ☐ If Yes, how: ☐ Eat more: ○ Vegetables ○ Fruit ○ Protein ○ Milk ○ Bread ○ Other: _____
☐ Eat less: ○ Vegetables ○ Fruit ○ Protein ○ Milk ○ Bread ○ Other: _____

Coping Skills

94. Are you currently having problems/concerns with any of the following? (check all that apply)

	0-13 wks:	14-27 wks:	28-40 wks:
None	☐	☐	☐
Divorce/separation	☐	☐	☐
Recent death	☐	☐	☐
Illness (TB, cancer, abn. pap smear)	☐	☐	☐
Unemployment	☐	☐	☐
Immigration	☐	☐	☐
Legal	☐	☐	☐
Probation/parole	☐	☐	☐
Child Protective Services	☐	☐	☐
Other: _____		Other: _____	Other: _____

95. What things in your life do you feel good about? _____

96. What things in your life would you like to change? _____

97. What do you do when you are upset? _____

98. In the past month, how often have you felt that you could not control the important things in your life?
☐ Very often ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

99. Have you ever attended group or individual meetings for emotional support or counseling? ☐ No
☐ If Yes, when and why? _____
☐ Yes Have you ever been prescribed drugs for emotional problems? ☐ What? _____ ☐ No
☐ Yes Have you ever been hospitalized for emotional problems? ☐ What year? _____ ☐ No

100. What do you do when you and your partner have disagreements? _____

101. Does your partner or other family member(s) use drugs and/or alcohol? ☐ No ☐ If Yes, does this create problems for you?
☐ No ☐ If Yes, Please explain: _____

102. Do you ever feel afraid of, or threatened by your partner? ☐ No ☐ If Yes, please explain: _____

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103. Within the last year have you been hit, slapped, kicked, choked or physically hurt by someone? ↙ ☐ No
☐ If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

104. Since you have been pregnant, have you been hit, slapped, kicked, choked or physically hurt by someone? ↙

0-13 wks: ☐ No ☐ If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

14-27 wks: ☐ No ☐ If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

28-40 wks: ☐ No ☐ If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

105. Within the last year has anyone forced you to have sexual activities? ↙ ☐ No ☐ If Yes, by whom (circle all that apply)

0-13 wks: ☐ No ☐ If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

14-27 wks: ☐ No ☐ If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

28-40 wks: ☐ No ☐ If Yes, by whom (circle all that apply) Husband Ex-husband Boyfriend Stranger Other Multiple
Total Number of Times: _____

106. Are your children, or have your children ever been, a victim of violence or sexual abuse? ↙ ☐ No
☐ If Yes, please explain: _____

107. Would you feel comfortable talking to a counselor if you had a problem? ☐ No ☐ Yes

Initial Assessment Completed by:

Name and Title	Initials	Date	Minutes

Second Trimester Reassessment Completed by:

Name and Title	Initials	Date	Minutes

Third Trimester Reassessment Completed by:

Name and Title	Initials	Date	Minutes

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