

To be completed with each participant at intake.

Performance Measure	Question #	Question	Staff Instructions	Response	Grantees Feedback
Name: _____ Completed by: _____ Date of Completion: _____					
To be completed with each participant at intake.					
<b>Please read the following statement to the participant:</b> Thank you for participating in this evaluation of the Healthy Start program. The purpose of the evaluation is to examine how well the Healthy Start program is meeting its goals of helping women to improve their health and the health of their babies. This questionnaire should take about 25 minutes to complete. Any information you provide will be kept confidential, and your identity will be known only to myself and to the Director of our program here. You do not have to answer any questions you do not want to, and you can end the interview at any time without any penalty or loss of benefits.					"Any information you provide will be kept confidential, and your identity will be known only to myself and to the Director of our program here." Will not work for all sites. Evaluation staff will have access to information for quality assurance.
Participant General Information					
<b>Please read the following to the participant:</b> First, I'd like to ask you some general background questions. Asking these questions gives us a better idea of the needs of Healthy Start participants, so we can serve you better.					In the "Children" form, all of staff's dialogue was indicated in red. Keep your instruction formatting consistent with forms to ensure they are administered consistently. Add the following response options: <input type="checkbox"/> Non-binary <input type="checkbox"/> Declined to answer
1	Gender of client		<b>Please read the following to the participant:</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Under 20 years old <input type="checkbox"/> 20-25 years <input type="checkbox"/> 26-30 <input type="checkbox"/> 31-35 <input type="checkbox"/> 36-40 <input type="checkbox"/> 41-50 <input type="checkbox"/> 51-60 <input type="checkbox"/> Over 60 <input type="checkbox"/> Decline to answer	
2	Can I ask which of the following age ranges you fall into?				Best practice for data collection and analysis is to collect the raw data fields (date of birth, enrollment date, form completion date) and classify in age ranges during analysis if desired.
3	Have you been with the Healthy Start program less than a month total or more than a month total? This includes periods of participation that might have happened in the past.		[Staff: Select ONE of the options below. Indicate total amount of time the participant has been in HS, including periods of time that happened in the past.]		Delete this question and corresponding questions. Too difficult for HS participant to recall. Define definition of past. Is past mean ever? In the grant cycle?
3a	How many days or weeks have you been with Healthy Start?		[If participant says she has been in HS for less than 1 month, ask question below and use days OR weeks to estimate total amount of time]	<input type="checkbox"/> ____ Days OR <input type="checkbox"/> ____ Weeks	
3b	How many months or years have you been with Healthy Start?		[If participant has been in HS for MORE THAN 1 MONTH, ask question below and use months OR years to estimate total amount of time]	<input type="checkbox"/> ____ Months OR <input type="checkbox"/> ____ Years	
4	Now I'd like to ask about the area where you live. Is it:		<b>Select one only</b>	<input type="checkbox"/> Rural <input type="checkbox"/> Urban <input type="checkbox"/> Suburban  <input type="checkbox"/> Less than high school <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college/formal training beyond high school <input type="checkbox"/> College graduate or more <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Is this not defined by HS grantee classification? Urban and suburban classifications can be confusing to participants. This will lead to inconsistent answers. Is the address no longer being asked? How is community area to be verified during audits etc.
5	Can you tell me what the highest grade or year of school is that you have		<b>Select one only</b>		Okay
6	Are you of Hispanic origin?		<b>Select one only</b>	<input type="checkbox"/> No (neither biological parent is of Hispanic, Latino, or Spanish origin) <input type="checkbox"/> Yes (one or both biological parents is of Hispanic, Latino, or Spanish origin)	Patients should be allowed to identify as being of hispanic origin. Add the following response options: <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer
7	What is your racial background?		<b>Select one only response. If participant lists more than one background below, select 'Multiracial.'</b>	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Multiracial <input type="checkbox"/> White or Caucasian <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Okay, please consider changing the aggregate report if you are going to change these response options.
8	Do you speak a language other than English at home?		<b>Select one only</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Previously there was a follow-up questions asking the language. We suggest asking the participant's primary language as well to make sure the education material is provided in the best language for the participant and family members.
Participant Health Care					
Next, I'd like to ask you some questions about your current health care. Collecting this information gives us a better idea of our clients' experiences and needs, so we can improve the services we offer.					
Usual Source of Care, Woman	9	A personal doctor or nurse is a health professional who knows you well and is familiar with your health history. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician's assistant. Do you have one or more persons you think of as your personal doctor or nurse?	<b>Select one only</b>	<input type="checkbox"/> Yes, one person <input type="checkbox"/> Yes, more than one person <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Okay
Usual Source of Care, Woman	10	Is there a place that you USUALLY go to for care when you are sick or need advice about your health?	<b>Select one only</b>	<input type="checkbox"/> Yes, one place <input type="checkbox"/> Yes, more than one place <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Previously collected location the participant goes for most often when sick or needs advice. It's bias to just know that a participant has a usual source of care but we don't know that it's the ER or other urgent care facility.
Insurance, Woman	14	Can you please tell me what kind of health insurance you currently have? Select one primary health insurance that you use to cover your own visits to your primary care provider for either sick care or preventive care, such as an annual physical exam.	<b>Select one only</b>	<input type="checkbox"/> Private insurance through my job, or the job of my husband, partner or parents <input type="checkbox"/> Insurance purchased directly from an insurance company, including the health exchange ("Obamacare") <input type="checkbox"/> Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability <input type="checkbox"/> Other, including TRICARE, Indian Health Service, military health care, or any other type of insurance that doesn't fall into one of the above categories <input type="checkbox"/> No insurance <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Number is inconsistent #11 Question and responses okay
Well Woman	11	During the past 12 months, did you see a doctor, nurse, or other health care worker for preventive medical care, such as a physical or well visit checkup?	<b>Select one only</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to Answer	Number is inconsistent #12 Question and responses okay
Pregnancy and Childbirth History					
Next, I'd like to ask you some questions about your pregnancy and childbirth history.					
12	Are you pregnant now?		<b>Select one only</b>	<input type="checkbox"/> Yes [Complete the Prenatal Mandatory Questions] <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Number is inconsistent #13 Question and responses okay
13	Have you had any previous pregnancies?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Okay
14	Do you have any children you have legally adopted?			<input type="checkbox"/> Yes [Complete the Interconception/Parenting questionnaire] <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	**Postpartum/Interconception mandatory questions" should read Healthy Start Mandatory Questions: Children based on new screening tool titles Why would you complete the questionnaire if you have adopted children? Age matters. Only if you have adopted children under the age of 18 months. (new grant cycle HS is only serving infants/children under that age of 18 months)
If participant has had no previous pregnancies and has no legally adopted children, this section is complete. Please move on to the final section on Personal Well-Being.					
If participant has had at least one previous pregnancy or at least one adopted child, then ask the following questions.					
15	How many living children, including biological or legally adopted, do you have, including both children who live with you and children who might live elsewhere?			<input type="checkbox"/> Number living biological children: _____ <input type="checkbox"/> Number living adopted children: _____	Suggest using "non-biological" or "guardianship" instead of "adopted" Reword question: How many living children do you have, including biological, legally adopted, or not living with you?
16	How many of your children who live with you are under 24 months of age?		[Skip this question if there are no living children. If there is at least one living child, either biological or adopted, ask]	<input type="checkbox"/> _____ [if participant has a child under 24 months old who is living with them, complete the Postpartum/Interconception mandatory questions.]	In the new grant cycle HS is only serving infants/children under that age of 18 months. Therefore, this should read 18 months NOT 24 months. **Postpartum/Interconception mandatory questions" should read Healthy Start Mandatory Questions: Children based on new screening tool titles Suggestion: use non-biological instead of adopted.
17	Have you ever had an ectopic pregnancy, a miscarriage (baby dies before 20 weeks of pregnancy) or a stillbirth (baby dies after 20 weeks of pregnancy)?		<b>Select all that apply.</b>	<input type="checkbox"/> Ectopic pregnancy <input type="checkbox"/> Miscarriage <input type="checkbox"/> Stillbirth <input type="checkbox"/> None <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	These questions reads as a Yes/No question. The response option should be No and NOT None. What about previous abortions?
18	Does this participant have a current Reproductive Life Plan on file?			<input type="checkbox"/> Yes <input type="checkbox"/> No	Define current. Suggest documenting the Reproductive Life Plan
If participant has no living biological children, or only legally adopted children, this section is complete. Please move on to the section on Personal Well-Being.					
If participant has biological children either living with her or elsewhere, ask the following questions regarding her previous pregnancies.					
So, I'd like to ask you a few questions about how your previous pregnancies went.					

	19	First, have you ever had a baby by cesarean delivery, or c-section (when a doctor cuts through the mother's belly to bring out the baby)?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	"Cesarean delivery, or c-section" reads as two separate items. Suggest: cesarean delivery/c-section
	20	Were any of your babies born more than 3 weeks before their due date?	Select one only	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Suggest capturing the following: Yes, specify how many _____ This was asked previously
	21	Did any of your babies weigh less than 5 pounds, 8 ounces at birth?	Select one only	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Suggest capturing the following: Yes, specify how many _____ This was asked previously
	22	Were any of your babies admitted to the Neonatal Intensive Care Unit (NICU)?	Select one only	<input type="checkbox"/> Yes, please specify reason(s): _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Previous questions was: "Did any of your babies stay in the hospital after you came home?" This is an improved question. "Please specify reason(s):" Text fields will be difficult to do any analysis with. Suggest a follow up multiple choice question with common responses (premature, difficulties occur during delivery, amnesia, apnea, etc.)
	23	<u>Have</u> you had a baby who <u>died in</u> his or her <u>first year of life</u> ?	Staff: if yes, <u>empathize with mother and provide her emotional support as she describes this and deals with pain of discussing it before completing final section below. If necessary, complete the final section and any additional required questionnaires at a later time.</u>	<input type="checkbox"/> Yes, please specify reason(s): _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Sensitive question to ask why the baby died.  *Is there a timeline for completing the questionnaire?
Personal Well-Being					
Next, we're going to ask you some questions about how you're doing in day to day life, that is, your own sense of personal well-being. We'll start with a couple questions about income because the financial resources available to us can have a big impact on stress in our daily lives.					
	24	First, I'm going to give you some income ranges. Can you tell me what range the annual income of your household falls into? This would be total yearly total household income before taxes. Please include all sources of income including your husband's or partner's income, and any other income you may have received. This information will be kept confidential and will not affect any services you are now getting.	Select one only	<input type="checkbox"/> Less than \$10,000 <input type="checkbox"/> \$10,000 to less than \$15,000 <input type="checkbox"/> \$15,000 to less than \$20,000 <input type="checkbox"/> \$20,000 to less than \$25,000 <input type="checkbox"/> \$25,000 to less than \$35,000 <input type="checkbox"/> \$35,000 to less than \$50,000 <input type="checkbox"/> \$50,000 or more <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Okay
	25	Can you tell me how many people are supported by this income?	STAFF: Enter number of people.	<input type="checkbox"/> ____ Adults age 18 or older <input type="checkbox"/> ____ Children age 17 or younger <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Okay
	26	Next I'm going to ask you a couple questions about how your mood has been lately. Over the past two weeks, how often have you experienced either of the following-- would you say never, several days, more than half the days, or nearly every day?	STAFF: Read each item to participant, and check one score for each question.	PHQ-2 Questions	Suggest collecting the date of the PHQ-2 screening.  Previously collected the follow-up assessment which was a benchmark. Suggestion is to collect data (score and date) on the follow up assessment
Depression Screening	27	Staff: has this participant completed the depression screening in the previous question?	NOTE: Enter the number that matches the participant's answer in the last column, and add the answers for both together to get the final score. If the final score is MORE THAN 2, further assessment is needed.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Could also be helpful to collect information if participant was referred after screening.
Depression Screening	28	The next question asks about substances that some people use. In the past 12 months, how often have you used each of the following?	STAFF: Read substances and answers to participant and enter one response for each substance.	Table	Why is this question necessary? You know if the PHQ-2 was complete because the data points have been completed.
	28a	Alcohol, including beer and wine coolers		<input type="checkbox"/> Never!! <input type="checkbox"/> A few or several times a year but less than once a month!! <input type="checkbox"/> Once or Twice Monthly!! <input type="checkbox"/> Weekly!! <input type="checkbox"/> Daily or Almost Daily!! <input type="checkbox"/> Declined to answer	Okay
	28b	Tobacco products, including e-cigarettes and vaping		<input type="checkbox"/> Never!! <input type="checkbox"/> A few or several times a year but less than once a month!! <input type="checkbox"/> Once or Twice Monthly!! <input type="checkbox"/> Weekly!! <input type="checkbox"/> Daily or Almost Daily!! <input type="checkbox"/> Declined to answer	Okay
	28c	Marijuana		<input type="checkbox"/> Never!! <input type="checkbox"/> A few or several times a year but less than once a month!! <input type="checkbox"/> Once or Twice Monthly!! <input type="checkbox"/> Weekly!! <input type="checkbox"/> Daily or Almost Daily!! <input type="checkbox"/> Declined to answer	Okay
	28d	Opioids or other pain medications (morphine, codeine, oxycodone, Vicodin, methadone, etc.)		<input type="checkbox"/> Never!! <input type="checkbox"/> A few or several times a year but less than once a month!! <input type="checkbox"/> Once or Twice Monthly!! <input type="checkbox"/> Weekly!! <input type="checkbox"/> Daily or Almost Daily!! <input type="checkbox"/> Declined to answer	Okay
	28e	Other drugs (cocaine, crack, heroin, meth, PCP, LSD, etc.)		<input type="checkbox"/> Never!! <input type="checkbox"/> A few or several times a year but less than once a month!! <input type="checkbox"/> Once or Twice Monthly!! <input type="checkbox"/> Weekly!! <input type="checkbox"/> Daily or Almost Daily!! <input type="checkbox"/> Declined to answer	Okay
	29	This is our last question. We are concerned about the safety of all participants. Please answer the following questions about experiences that you may have had in the last 12 months so that we can help you if needed	STAFF: Please read each question to participant and enter one response for each question.	Table	Okay
IPV	29a	Did your husband or partner threaten or make you feel unsafe in some way?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Okay
IPV	29b	Were you frightened for your safety or your family's safety because of the anger or threats of your husband or partner?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Okay
IPV	29c	Did your husband or partner try to control your daily activities, for example, control who you could talk to or where you could go?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Okay
IPV	29d	Did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Okay
IPV	29e	Did your husband or partner force you to take part in touching or any sexual activity when you did not want to?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Okay
IPV	29f	Did anyone else physically hurt you in any way?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Okay
IPV	30	Staff: has this participant completed the IPV screening in the previous question?	Staff: if a participant answers yes to one or more questions in this section, pause the interview to provide support and resources.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Why is this question necessary? You know if the IPV screening was complete because the data points have been completed.

This tool should be completed as soon as possible for women in the prenatal period. The prenatal period refers to the time period from diagnosis of pregnancy to birth.

If a pregnant woman also has a child living with her who is under 24 months of age, then she should also complete the Postpartum/Interconception mandatory questions.

\*\*Postpartum/Interconception mandatory questions\* should read Healthy Start Mandatory Questions: Children based on new screening tool titles

Question #	Questions	Staff Instructions	Response Options	Grantees Feedback
If a pregnant woman also has a ch Name: _____ Completed by: _____ Date of Completion: _____				
This tool should be completed as soon as possible for women in the prenatal period. The prenatal period refers to the time period from diagnosis of pregnancy to birth.				
If a pregnant woman also has a child living with her who is under 24 months of age, then she should also complete the Postpartum/Interconception mandatory questions.				
Please read the following statement to the participant: Thank you for participating in this evaluation of the Healthy Start program. The purpose of the evaluation is to examine how well the Healthy Start program is meeting its goals of helping women to improve their health and the health of their babies. This questionnaire should take about 5 minutes to complete. Any information you provide will be kept confidential, and your identity will be known only to myself and to the Director of our program here. You do not have to answer any questions you do not want to, and you can end the interview at any time without any penalty or loss of benefits.				
PREGNANCY HEALTH AND HEALTH CARE				
For this questionnaire, I'd like to start off by asking you a couple questions about your pregnancy				
1	First, how many weeks or months pregnant are you?	STAFF: Please enter EITHER number of weeks OR number of months. Enter ONE only.	<input type="checkbox"/> ____ Weeks <input type="checkbox"/> OR ____ Months <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Okay
2	How many weeks or months pregnant were you when you had your first visit for prenatal care? Do not count a visit that was only for a pregnancy test or only for WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children).	STAFF: Please enter EITHER number of weeks OR number of months. Enter ONE only.	<input type="checkbox"/> ____ Weeks <input type="checkbox"/> OR ____ Months <input type="checkbox"/> I didn't go/haven't gone yet for prenatal care <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Okay
Substance Use				
Next, I'd like to ask you some additional questions about your use of alcohol and tobacco. We ask about these because they are known to have an impact on the developing baby.				
Smoking	3 Do you currently smoke any cigarettes or use any tobacco products?	Select one only.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Include questions about current use of marijuana and other drugs. Suggestion: Include the following questions and responses as well: *Do you currently smoke any marijuana or use any marijuana products? (Yes, no, decline to answer) *Do you currently take any other drugs (cocaine, crack, heroin, meth, PCP, LSD, etc.)? (Yes, no, declined to answer)
	4 Which of the following statements would you say best describes your current alcohol use, INCLUDING beer and wine coolers?	STAFF: Please read the following responses to participant. Select one only.	<input type="checkbox"/> I drink alcohol regularly now – about the same as before finding out I was pregnant <input type="checkbox"/> I drink alcohol regularly now but I've cut down since I found out I was pregnant <input type="checkbox"/> I drink alcohol every once in a while <input type="checkbox"/> I have quit drinking alcohol since I found out I was pregnant <input type="checkbox"/> I wasn't drinking alcohol around the time I found out I was pregnant and I don't currently drink <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Okay
Family Activities				
Last, we have a couple questions about your home life and plans for the baby.				
	5 Do you plan to feed your new baby breastmilk, formula, or a combination?	Select one only.	<input type="checkbox"/> Breastfeed only (baby will not be given formula) <input type="checkbox"/> Formula feed only <input type="checkbox"/> Both breast and formula feed <input type="checkbox"/> Don't know yet <input type="checkbox"/> Declined to answer	Previous question: What method do you plan to use to feed your new baby in the first few weeks? New question is improved. Okay
	6 Women often turn to others for support when they are pregnant. Would you describe your partner or the father of this baby as:	Select one only. STAFF: Please read responses to participant.	<input type="checkbox"/> Involved in my pregnancy and supportive of me <input type="checkbox"/> Involved but not supportive of me <input type="checkbox"/> Aware that I'm pregnant but not involved <input type="checkbox"/> Not aware that I'm pregnant <input type="checkbox"/> Other [Specify] _____ <input type="checkbox"/> Declined to answer	This question was previously used for the male involvement - prenatal. Is this question only meant for male partners?
The Prenatal Mandatory Questionnaire is Complete				
Staff: Complete Pregnancy Follow-up Question Below PREGNANCY FOLLOW-UP				
	Date: _____		<input type="checkbox"/> Live birth - single baby or multiples (twins, triplets, etc.) Please indicate number of babies if multiples _____ <input type="checkbox"/> Miscarriage <input type="checkbox"/> Ectopic or tubal pregnancy <input type="checkbox"/> Fetal death/stillbirth <input type="checkbox"/> Outcome unknown	Is this the date the form is completed? Suggestion: Add abortion as a response option. Suggestion: Include the delivery date of the baby or babies as well as the date of the loss. Suggestion: more options for multiples if they experience different birth outcomes
	Staff: Record outcome of this pregnancy	Select one only.		**Postpartum/Interconception mandatory questions* should read Healthy Start Mandatory Questions: Children based on new screening tool titles.
If the outcome of the pregnancy was a live birth, please go on to complete the Postpart/Interconception HS mandatory questionnaire.				
If the outcome of the pregnancy was not a live birth (e.g., miscarriage, tubal or ectopic pregnancy, fetal death or stillbirth), staff need to be cognizant of the sensitivity of the mother, and potentially delay completing the appropriate questionnaire(s) until a more appropriate time.				
Follow-up questionnaires if pregnancy did not result in live birth:				
If mother has no children under 24 months of age who are living with her, then use the background mandatory questionnaire only				
If mother has a child under 24 months of age living with her, then use the Postpart/Interconception HS mandatory questionnaire in addition to the mandatory background questionnaire				

Performance Measure	Question #	Question	Staff Instructions	Response	Grantees Feedback
		Name: _____ Completed by: _____ Date of Completion: _____			
This form should be used with women who are currently parenting a child younger than 24 months of age. If she is also pregnant, then she will need to complete both this questionnaire and the prenatal questionnaire, in addition to the general background questionnaire.				In the new grant cycle HS is only serving infants/children under that age of 18 months. Therefore, this should read 18 months <b>NOT 24 months</b> .	
Please read the following statement to the participant: Thank you for participating in this evaluation of the Healthy Start program. The purpose of the evaluation is to examine how well the Healthy Start program is meeting its goals of helping women to improve their health and the health of their babies. This questionnaire should take about 20 minutes to complete. Any information you provide will be kept confidential, and your identity will be known only to myself and to the Director of our program here. You do not have to answer any questions you do not want to, and you can end the interview at any time without any penalty or loss of benefits				*Any information you provide will be kept confidential, and your identity will be known only to myself and to the Director of our program here." Will not work for all sites. Evaluation staff will have access to information for quality assurance.	
Birth Intervals for Past 24 Months					
In this questionnaire, we're going to focus on questions that relate to the health of your baby. The first few questions ask about birth spacing. The spacing of children—that is, how far apart in age they are—can have an impact on your health. The next few questions are meant to help us understand how recent birth spacing has been for you					
Birth Spacing?	1	Can you please tell me the dates of birth and ages of your children living at home with you who are under 24 months old?	[Staff: provide age of child(ren) at time of administration. Use only one row for a birth with multiples.]	Table	In the new grant cycle HS is only serving infants/children under that age of 18 months. Therefore, this should read 18 months NOT 24 months.
	1a	Child 1 (Only or older child under 24 months old; use only one row for a single pregnancy that resulted in multiples)		<input type="checkbox"/> Date of birth _____ <input type="checkbox"/> Date of Administration _____ <input type="checkbox"/> Current Age _____(Months) <input type="checkbox"/> Type _____(Singleton, Multiples) <input type="checkbox"/> Declined to Answer	In the previous screening tools pregnancy history was collected starting with the most recent. Suggestion: Keep ordering of pregnancy history consistent for staff working with participants and entering data to reduce data entry errors: 1) Current pregnancy first 2) Child 1 - youngest child 3) Child 2 - oldest child under 18 months.
Birth Spacing?	1b	Child 2 (Younger child or leave blank if only one child under 24 months; use only one row for a single pregnancy that resulted in multiples)		<input type="checkbox"/> Date of birth _____ <input type="checkbox"/> Date of Administration _____ <input type="checkbox"/> Current Age _____(Months) <input type="checkbox"/> Type _____(Singleton, Multiples) <input type="checkbox"/> Declined to Answer	Suggest asking if biological or non-biological in this table
	1c	Current Pregnancy?	Staff: If participant is currently pregnant, she should also complete the HS mandatory Prenatal Questions.	<input type="checkbox"/> Est due date: _____ <input type="checkbox"/> OR Not pregnant <input type="checkbox"/> Declined to Answer	Suggest editing to "Currently Pregnant?"
	2	Are these children biological or legally adopted?		<input type="checkbox"/> Biological <input type="checkbox"/> Legally adopted <input type="checkbox"/> Both	Our site primarily works with biological children however we do have situation where a grandmother or other guardian is taking care of a child. They are not legally adopted. Suggestion: Add guardianship which can include plenary guardian, standby guardian, short-term guardian.
Birth Spacing?	3	Is there at least an 18-month interval between the birth dates of Child 1 and Child 2 above? [Do NOT count multiples from the same pregnancy as separate births.]	Staff: For biological children only, in cases where two children are under 24 months.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Participant has only one child under age 24 months old <input type="checkbox"/> One or both children was legally adopted	Questions of this nature should be calculated using evaluation staff not program staff. In the new grant cycle HS is only serving infants/children under that age of 18 months. Therefore, this should read 18 months NOT 24 months. Suggestion: update the staff instructions to read two children under 18 months.
Birth Spacing?	4	Is there at least an 18 month interval between the estimated due date for any current pregnancy and the most recent live birth for this participant?	Staff: For biological children only	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Participant has only one child under age 24 months old <input type="checkbox"/> One or both children was legally adopted	Questions of this nature should be calculated using evaluation staff not program staff. This question is for pregnant women only Suggestion: update staff instructions: "Staff: For biological children only and for mothers currently pregnant"
When there is more than one child younger than 24 months old, the participant should answer the following questions for the OLDER/OLDEST child only.					
Health at Birth					
Staff, if participant has more than one child under 24 months of age, say: For the purposes of this questionnaire, we are going to focus only on one child who is under 24 months of age and living with you. If you have more than one child who meets those criteria, we ask you to focus only on the OLDEST of those children. All remaining questions ask about that child only. This child will be the Target Child of these questions. Staff, continue with all participants and say:					
	1	First, what is your relationship to the Target Child?		<input type="checkbox"/> Mother (biological, step, or legally adopted) <input type="checkbox"/> Father (biological, step, or legally adopted) <input type="checkbox"/> Grandmother <input type="checkbox"/> Other relative <input type="checkbox"/> Other (legal guardian, foster, other non-kin relationship)	Suggestion: Move this question to the birth interval section and collect this information in the table in question 1. Suggestion: Use a different term than "Target Child."
Next, we're going to ask you some questions about yours and the Target Child's health when he/she was born.					
	2	How many weeks pregnant were you [or the biological mother if adopted] when he/she was born?	STAFF: Please enter number of weeks. If child is adopted, change 'you' to 'the biological mother'	_____weeks <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Separate into two questions. One for adopted children and one for biological. The wording is confusing for staff administering the screening tools and will lead to choppy, confusing data collection. Suggestion: "STAFF: Please enter number of weeks. If child is adopted, change 'were you' to 'was the biological mother'."
	3	Was your baby's weight at birth either less than 5 pounds 8 ounces (2500 grams) or greater than 9 pounds 4 ounces (4200 grams)?		Yes, less than 5 pounds 8 ounces (2500 grams) Yes, more than 9 pounds 4 ounces (4200 grams) No, baby's weight was between 5 lb 8 oz and 9 lb 4 oz <input type="checkbox"/> Don't know <input type="checkbox"/> Declined to answer	Is this for biological children only? There are no instructions Suggestion: update instructions
	4	Did you or have you had a postpartum visit for yourself after this baby was born? A postpartum visit is the regular checkup a woman has 4-6 weeks after she gives birth.	[Staff: do not ask if child is legally adopted, but indicate N/A below] Select one only.	<input type="checkbox"/> Yes <input type="checkbox"/> Not yet--baby is still less than 6 weeks old <input type="checkbox"/> No, I did not have a postpartum visit within 6 weeks of this baby's birth <input type="checkbox"/> Don't know <input type="checkbox"/> N/A--child is legally adopted <input type="checkbox"/> Declined to answer	Separate into two questions. One for adopted children and one for biological. The wording is confusing for staff administering the screening tools and will lead to choppy, confusing data collection. Suggestion: Add date of visit Suggestion: Add the response options "No" and "Yes, postpartum visit later than 6 weeks postpartum." Or Suggestion: Use previous screening tool question
	5	How many weeks pregnant were you when you started prenatal care with this baby?		<input type="checkbox"/> _____Weeks <input type="checkbox"/> Did not have prenatal care while pregnant <input type="checkbox"/> Don't know <input type="checkbox"/> N/A--child is legally adopted <input type="checkbox"/> Declined to answer <input type="checkbox"/> Smoke cigarettes or other tobacco products, including vaping? -Yes -No <input type="checkbox"/> Drink alcohol including beer and wine coolers? -Yes -No <input type="checkbox"/> Use any other substances? -Yes; Please specify _____ -No <input type="checkbox"/> Don't know <input type="checkbox"/> N/A--child is legally adopted <input type="checkbox"/> Declined to answer	Concerned about the patients ability to recall this information. It mostly likely will not be accurate. Again suggesting asking questions for the youngest child for more accurate recall. Question reads as though it is only for mothers, not all participants. Suggest offering a date field for more accurate recall
	6	Did you do any of the following while pregnant with this child:	[Staff: circle yes or no under each item]		Instructions read as though this is to be collected on paper. Separating questions by "biological" and "non-biological" would make this section administered more smoothly. Question reads as though it is only for mothers, not all participants.
Infant Feeding					
The next few questions are about breastfeeding. [Staff: do not ask 'infant feeding' questions below if child is legally adopted, but indicate N/A for each question]					
Ever breastfed	7	Did you ever breast feed or pump breast milk to feed your baby after delivery, even for a short period of time?	Select one response only	<input type="checkbox"/> Yes (includes women who are still breastfeeding) <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> N/A--child is legally adopted <input type="checkbox"/> Declined to answer	Target child? Question reads as though it is only for mothers,not all participants.

			<div>STAFF: Please write in the number provided by the participant and enter number of days, weeks OR months for baby. Enter ONLY ONE time unit in the column. *If participant did not breast feed at all, then enter zero. *If participant is still/currently breastfeeding, provide total number of days, weeks, or months breastfed up till now. Enter ONLY ONE time unit in column.</div>	<div><input type="checkbox"/>Number of days, weeks OR months (record number next to appropriate time unit; if mother is still/currently breastfeeding, then this number will be the same as baby's current age) -Days _____ -OR Weeks _____ -OR Months _____ <input type="checkbox"/>Still/Currently breastfeeding -Yes -No <input type="checkbox"/>Don't know! <input type="checkbox"/>N/A—Child is legally adopted! <input type="checkbox"/>Declined to answer  <input type="checkbox"/>Yes <input type="checkbox"/>No, baby is less than 6 months old <input type="checkbox"/>No, child is older than 6 months but was not breastfed for at least 6 months <input type="checkbox"/>N/A—child is legally adopted <input type="checkbox"/>Don't know <input type="checkbox"/>Declined to answer</div>	<div>Target child? Question reads as though it is only for mothers If still/currently breastfeeding and child is under 6 months, evaluators will be unable to calculate duration</div>
8	How many days, weeks OR months did you breastfeed or pump breast milk for your baby? [Child 1]				
9	Staff: Was or has the baby been breastfed for at least 6 consecutive months?	Select one response only.			<div>Target child? Suggestion: Remove consecutive Why is this question necessary? This should be calculated by evaluation staff.</div>
Infant Sleep					
For children 12 months and older, check not applicable in each box and move to next section.				Separate questions for children 12 months or older or younger than 12 months	
[For babies less than 12 months old, say: ] Next we're going to ask some questions about sleeping. Good sleep habits are important to your baby's physical health and emotional well-being. An important part of safe sleep is the place where your baby sleeps, his or her sleeping position, the kind of crib or bed, and type of mattress.					
Safe Sleep	7	In what position do you usually lay your baby down to sleep? [Child 1]		<div><input type="checkbox"/>Side! <input type="checkbox"/>Back! <input type="checkbox"/>Stomach! <input type="checkbox"/>Not Applicable (baby is 12 months or older)</div>	<div>Child 1 is the oldest child in the Birth Intervals of Past 24 Months section. Table is confusing if this section is meant for babies less than 12 months old. This may be the oldest or not. Suggestion: Be consistent with safe sleep questions. Use the same safe sleep questions developed in the previous screening tools so benchmarks can be compared year to year. Suggestion: Clearly define what child you are talking about, and if this has potential to be different from the previously described "Child 1," use a different term. Or make all questions pertain to one child.</div>
Safe Sleep	8	Do you put your baby to sleep with or without blankets, toys, and crib bumpers? [Child 1]		<div><input type="checkbox"/>With! <input type="checkbox"/>Without! <input type="checkbox"/>Not Applicable (baby is 12 months or older)</div>	<div>Suggestion: Be consistent with safe sleep questions. Use the same safe sleep questions developed in the previous screening tools so benchmarks can be compared year to year. Suggestion: Add "Declined to Answer" as an option.</div>
Safe Sleep	9	Does your baby usually sleep in his/her own crib or bassinet? [Child 1]		<div><input type="checkbox"/>No! <input type="checkbox"/>Yes! <input type="checkbox"/>Not Applicable (baby is 12 months or older)</div>	<div>Suggestion: Be consistent with safe sleep questions. Use the same safe sleep questions developed in the previous screening tools so benchmarks can be compared year to year. Suggestion: Add "Declined to Answer" as an option.</div>
Child Health Care					
These next few questions are about your child's health care. A personal doctor or nurse is a health professional who knows your child well and is familiar with your child's health history. This can be a general doctor, a pediatrician, a specialist doctor, a nurse practitioner, or a physician's assistant.				What child are we talking about in this section? Target child? Child under 12 months? Suggestion: Clarify instructions Child 1 is the oldest child in the Birth Intervals of Past 24 Months section. Tables throughout this section use Child child. The tables are confusing. Suggestion: be consistent with labeling	
Usual Source of Ca	10	Do you have one or more persons you think of as your child's personal doctor or nurse? [Child 1]	Select one response only.	<div><input type="checkbox"/>Yes, one person! <input type="checkbox"/>Yes, more than one person! <input type="checkbox"/>No! <input type="checkbox"/>Don't Know! <input type="checkbox"/>Declined to Answer <input type="checkbox"/>Yes! <input type="checkbox"/>No! <input type="checkbox"/>There is more than one place! <input type="checkbox"/>Don't Know! <input type="checkbox"/>Declined to answer <input type="checkbox"/>Number of days, OR weeks OR months ago (Record number next to appropriate time unit. Enter ONE time unit only.) <input type="checkbox"/>Days ago _____ <input type="checkbox"/>OR Weeks ago _____ <input type="checkbox"/>OR Months ago _____ <input type="checkbox"/>Age at last visit (Record number next to appropriate time unit. Enter ONE time unit only.)</div>	<div>Okay</div>
Usual Source of Ca	11	Is there a place that your child USUALLY goes for care when he or she is sick or when you need advice about your child's health? [Child 1]	Select one response only.	<div><input type="checkbox"/>Declined to answer <input type="checkbox"/>Number of days, OR weeks OR months ago (Record number next to appropriate time unit. Enter ONE time unit only.) <input type="checkbox"/>Days _____ <input type="checkbox"/>OR Weeks _____ <input type="checkbox"/>OR Months _____</div>	<div>Previously collected location the child is taken most often when sick or needs advice. It's bias to just know that a participant has a usual source of care but we don't know that it's the ER or other urgent care centers.</div>
Well Child Visit	12	How long ago was your child's last visit to a doctor, nurse, or other health provider for a well-child check-up? [Child1]	Complete ONE time unit only.	<div><input type="checkbox"/>Days _____ <input type="checkbox"/>OR Weeks _____ <input type="checkbox"/>OR Months _____ <input type="checkbox"/>Age at last visit (Record number next to appropriate time unit. Enter ONE time unit only.)</div>	<div>How is the well child visit going to be calculated? Suggestion: collect the date of the well child visit</div>
Well Child Visit	13	So how old was your child at this last well check-up visit? [Child1]	Complete ONE time unit only.	<div><input type="checkbox"/>Days _____ <input type="checkbox"/>OR Weeks _____ <input type="checkbox"/>OR Months _____</div>	<div>How is the well child visit going to be calculated? Suggestion: collect the date of the well child visit</div>
Well Child Visit	14	Staff: was this well-child visit within the time frame recommended for this child's age?		<div><input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>Unable to determine</div>	<div>Should be calculated by evaluation</div>
Health Insurance, Child	15	Please tell me what kind of health insurance your child currently has. Select ONE primary health insurance that you use to cover this child's visits to his/her primary care provider for either sick care or well-child care. [Child 1]	Select only ONE.	<div><input type="checkbox"/>Private health insurance through my job, or the job of my husband, partner or parents <input type="checkbox"/>Insurance purchased directly from an insurance company, including from the health exchange ("Obamacare") <input type="checkbox"/>Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability <input type="checkbox"/>Other, including TRICARE, Indian Health Service, military health care, or any other type of insurance that doesn't fall into one of the above categories <input type="checkbox"/>No insurance <input type="checkbox"/>Don't know <input type="checkbox"/>Declined to answer</div>	<div>Target child?</div>
FAMILY LIFE					
For babies younger than 6 months, check not applicable in the box for question 16 and proceed to question 17.				Why is this restricted to only children over 6 month? Further, if there are 2 children but both over 6 months, which child are you wanting this informaton on?	
[For children who are 6 MONTHS OR OLDER, say: ] Last, we have a couple questions about your family life.					
16	Can you tell me the number of days you or a family member read to your child during the past week? Reading includes books with words or pictures but NOT books read by an audio tape, record, CD, or computer.	[Staff: If child is younger than 6 months, check not applicable and move to next question. If child is 6 months or older, ask:]		<div><input type="checkbox"/>Days per week (Record the number)! <input type="checkbox"/>Not applicable (child less than 6 months old)! <input type="checkbox"/>Don't know! <input type="checkbox"/>Declined to answer</div>	<div>This question assumes literacy of parents. Suggestion: ask another question about using audio tie, record, CD or computer</div>
17	Finally, this is our last question. Often parents look to others for support and help when they have young children. Would you describe your partner or the father of your child as:	STAFF: Please read responses to participant, and select only one response.		<div><input type="checkbox"/>Involved and supportive of me and my child <input type="checkbox"/>Involved with child but not supportive of me <input type="checkbox"/>Not regularly involved in child's life <input type="checkbox"/>Declined to answer</div>	<div>This question was previously used for the male involvement - postpartum. Is this question only meant for male partners? What if the participant is male? Suggestion: Add the following responses N/A deceased, incarcerated, etc. Suggestion define involvement</div>
The Postpartum/interconception Mandatory Questionnaire is Complete					