Healthy Start Program Visit Form - Adult

***Name of Participant:** _____

***Today's Date:** _____/_____/_____

***Healthy Start Agency/Clinic: (select one)**

- ☐ Health Department
- ☐ JCYC
- ☐ Flint Hills
- ☐ GCHF
- ☐ USD 475
- ☐ GC Hospital
- ☐ Konza Prairie CHC

***Address:** _____

***City and Zip Code:** _____

***County of Residence**: _____

Phone No: _____ - _____ - _____

Email: _____

Preferred Method of Contact: (check all that apply)

- ☐ Phone call
- ☐ Text
- ☐ Email
- ☐ Mail
- ☐ Do Not Contact

***Were you born in the US (including the Virgin Islands)? (select one)**

- ☐ Yes, born in the US
- ☐ No, not born in the US — **If No, what country were you born in?** _____
- ☐ Don't know
- ☐ Refused

***Program: (select one)**

- ☐ Becoming A Mom
- ☐ Family Planning
- ☐ Maternal Child Health (MCH/M&I)
- ☐ Pregnancy Maintenance (PMI)
- ☐ Teen Pregnancy (TPTCM)
- ☐ WIC
- ☐ Family practice
- ☐ Flint Hills OB/GYN
- ☐ OB Navigator
- ☐ Parents as Teachers
- ☐ Pediatrics
- ☐ Triple P
- ☐ Baby and Me Tobacco Free
- ☐ Universal Home Visiting
- ☐ LYFTE
- ☐ Breastfeeding Clinic
- ☐ Luke's Community Baby Shower
- ☐ MOD Smoking Cessation
- ☐ Conscious Fathering
- ☐ 24/7 Dad

How did you hear about this program? (check all that apply)

- ☐ Radio Ad
- ☐ Facebook Page
- ☐ Website
- ☐ Friend or Family Member
- ☐ Medical Provider
- ☐ Other — **If other, please specify:** _____

***Primary Healthcare Coverage: (select one)**

- ☐ None/Self Pay
- ☐ Private Insurance
- ☐ Tricare
- ☐ KanCare/Medicaid
- ☐ CHIP (Formerly HealthWave)
- ☐ Other Public Insurance
- ☐ Unknown/Not Reported

***Secondary Healthcare Coverage: (select one)**

- ☐ None
- ☐ Private Insurance
- ☐ Tricare
- ☐ KanCare/Medicaid
- ☐ CHIP (Formerly HealthWave)
- ☐ Other Public Insurance
- ☐ Unknown/Not Reported

*** Do you have a Regular Medical Provider (like a doctor or clinic) that you see for your medical care?**

- ☐ No
- ☐ Yes — **If Yes, Provider/Clinic Name:** _____

***Have you had a well visit during the past 12 months? (select one)**

- ☐ Yes
- ☐ No
- ☐ Client is unsure

***Do you have a special health care need or disability?**

- ☐ Yes
- ☐ No

***Do you care for any children who have special health care needs?**

- ☐ Yes
- ☐ No

***Household Size: (number of people) _____**

***Annual Household Income: $_____**

***Annual Household Income: (select range)**

- ☐ Less than $10000
- ☐ $10000 to $14999
- ☐ $15000 to $19999
- ☐ $20000 to $24999
- ☐ $25000 to $34999
- ☐ $35000 to $49999
- ☐ $50000 or more
- ☐ Don't know
- ☐ Refused

***Support person with you at time of visit: (check all that apply)**

- ☐ None
- ☐ Child's mother
- ☐ Child's father
- ☐ Child's grandmother
- ☐ Child's grandfather
- ☐ Child's (adult) sister
- ☐ Child's (adult) brother
- ☐ Child's Uncle
- ☐ Child's Aunt
- ☐ Adult Friend of Family (Female)
- ☐ Adult Friend of Family (Male)
- ☐ Other Female
- ☐ Other Male

If support person present is "Other Female" or "Other Male," please specify: _____

Male support person #1: (select one)

- ☐ 17 and under
- ☐ 18 and over
- ☐ Age unknown

Male support person #2: (select one)

- ☐ 17 and under
- ☐ 18 and over
- ☐ Age unknown

***Education Level: (select one)**

- ☐ Less than High School
- ☐ High School Diploma or GED
- ☐ Vocational Certification or License
- ☐ Some College, No Degree
- ☐ Associates Degree
- ☐ Bachelor Degree or Higher

***Are you currently a student?**

- ☐ Yes
- ☐ No

***Employment: (select one)**

- ☐ Unemployed
- ☐ Occasional/Seasonal Employment
- ☐ Part-Time
- ☐ Full-Time

***Marital Status: (select one)**

- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

***Do you smoke?**

- ☐ No
  - **If no, have you ever smoked?**
    - ☐ No
    - ☐ Yes **If yes, how long did you smoke? (years) ____**

      When did you quit? (age) ____
- ☐ Yes
  - **If yes, how many cigarettes per day? ____**

    When did you begin smoking (age)? ____

If you are pregnant, did you: (select one)

- ☐ Decrease during pregnancy
- ☐ Increase during pregnancy
- ☐ No change during pregnancy
- ☐ Stopped smoking during pregnancy
- ☐ N/A – Not pregnant

***Do you drink alcohol or use other substances?**

☐ No

☐ Yes **If yes, how often do you drink or use other substances? (select one)**

- ☐ Occasional/Social
- ☐ Weekly
- ☐ Daily

If Daily, how much per day?

_____

If you are pregnant, have you: (select one)

- ☐ Decreased during pregnancy
- ☐ Increased during pregnancy
- ☐ No change during pregnancy
- ☐ Stopped drinking/using other substances during pregnancy

***Are you pregnant? (select one)**

☐ No **Would you (and/or your partner) like to become pregnant in the next year? (select one)**

- ☐ Yes
- ☐ No
- ☐ Client is unsure
- ☐ Client is ok either way
- ☐ N/A - Services for infant or child

☐ Yes **If yes, what's your due date?**

_____

What trimester are you in? (select one)

- ☐ 1st (1-13 weeks)
- ☐ 2nd (14-27 weeks)
- ☐ 3rd (28+ weeks)

What trimester did you begin receiving prenatal care? (select one)

- ☐ 1st (1-13 weeks)
- ☐ 2nd (14-27 weeks)
- ☐ 3rd (28+ weeks)

☐ N/A-Services for infant, child, or male

***Have you given birth in the past year?**

☐ No

☐ Yes **If yes, are you breastfeeding? (select one)**

- ☐ Yes
- ☐ No **If you are not currently breastfeeding, did you initiate breastfeeding at birth?**
  - ☐ No
  - ☐ Yes

If you did initiate breastfeeding at birth, but are no longer breastfeeding, how long did you breastfeed? (# of days, weeks, or months)

_____

***Health Care Enrollment Assistance – ACA: (select one)**

- ☐ On-site assistance
- ☐ Off-site assistance
- ☐ Did not provide assistance

***Health Care Enrollment Assistance – Medicaid: (select one)**

- ☐ On-site assistance
- ☐ Off-site assistance
- ☐ Did not provide assistance

***Health Care Enrollment Assistance - Third party: (select one)**

- ☐ On-site assistance
- ☐ Off-site assistance
- ☐ Did not provide assistance