Kansas Department of Health and Environment DAISEY Delivering Change Healthy Moms - Healthy Babies Geary County Perinatal Coalition

Parental Health Screener

Name of Parent Involved? ____________________________ Date of Activity: _____/_____/_____

No	Yes	
☐	☐	Do you have reliable transportation?
☐	☐	Do you have a safe, stable place to live?
☐	☐	Do you have a reliable source of income?
☐	☐	Can you afford your monthly bills?
☐	☐	Are you behind in your rent/mortgage?
☐	☐	In the last 6 months, did you ever have trouble affording food?
☐	☐	Is your home in bad condition (i.e., no running water; no electricity; broken appliances)?

Is there someone in your household who will soon be deployed or coming home from deployment?

☐ No ☐ Yes

If yes, please specify below:

☐ No
☐ Deployed
☐ Coming home from deployment
☐ Soon to be deployed

Have you had a baby?

☐ No ☐ Yes **If yes,** have you had a baby born 3 weeks or more before the due date?

☐ No ☐ Yes

If yes, have you had a baby that weighed less than 5 pounds, 8 ounces?

☐ No ☐ Yes

If yes, have you had a baby that was not born alive?

☐ No ☐ Yes

If yes, have you had a baby that died within the 1st year of life?

☐ No ☐ Yes

If you have a child or children, how often do you or an adult family member read to/with your child(ren) during the week?

☐ Less than once a week
☐ 1-2 times per week
☐ 3-4 times per week
☐ 5-6 times per week
☐ Everyday
☐ N/A (I don't have a child)

If you have a child, when you discipline your child, do you lose control?

☐ No ☐ Yes ☐ N/A (No Children)

Are there children in your home with medical/special needs?

☐ No ☐ Yes

Is there someone living with you who currently smokes?

☐ No ☐ Yes

Have you smoked at least one cigarette in the past week?

☐ No ☐ Yes

In the past, have you had difficulties in your life due to substance use?

☐ No ☐ Yes

If yes, please specify below:

☐ Alcohol
☐ Drugs
☐ Prescription medication

Since becoming pregnant, have you had difficulties in your life due to substance use?

☐ No ☐ Yes

If yes, please specify below:

☐ Alcohol
☐ Drugs
☐ Prescription medication

Over the last 2 weeks, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?

☐ No ☐ Yes

Over the last 2 weeks, have you been feeling bad about yourself, or have you been feeling that you are a failure or have let yourself or your family down?

☐ No ☐ Yes

Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

☐ No ☐ Yes

Are you afraid of your partner or someone else who is important to you?

☐ No ☐ Yes