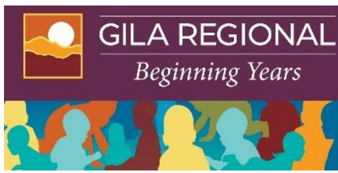


**Client Intake Form**

**Completed by:** __________

**Date:** __________________

**Referral Source:** __________________________

**Personal Information**

MOB _________________________ EDD_____________ ***or*** Child DOB __________________

DOB _____________Gender _____ Ethnicity__________Preferred Language______________

Mailing Address _______________________________________________________________

Physical Address ______________________________________________________________

Phone _________________________Text? Y N

Parenting Partner_________________________________DOB _____________Gender _____

Ethnicity___________ Preferred Language_____________Phone ______________Text? Y N

Other Children in home <5 years old

Name ______________________________ DOB __________________

Name ______________________________ DOB __________________

**Program Introduction**

*Introduce Beginning Years*

Your HV will cover variety of topics about parenthood- is there a specific topic you are interested in? _________________________________________________________________

_____________________________________________________________________________

*Conduct EPDS & attach to Intake/enter in DB* Score ______________________

If score 10 or above refer to MH services _____________ Referred to ___________________

**PN Information**

Are you/did you receive regular Prenatal care during your pregnancy? Medical Provider?

_____________________________________________________________________________

Did you have any health problems during this pregnancy or other medical issues?

_____________________________________________________________________________

Do you plan to breastfeed or formula feed? _________________________________________

**Postpartum Information**

Did you experience any complications during your delivery?

______________________________________________________________________

Do you have any concerns about your baby?

______________________________________________________________________

Are you breastfeeding or formula feeding? ______________________________________

**Supportive Relationships/Safety**

On a scale of 1 to 10 (1 feeling not supported/ 10 feeling very supported) how supported do you feel by family and friends? _______________________________________________

Are there any safety concerns in your home/neighborhood? ___________________________

______________________________________________________________________

Do you feel safe in your current relationship? (If No, why?) ___________________________

______________________________________________________________________

Is there anyone in your life you feel scared or threatened by? (Why?) __________________

______________________________________________________________________

**Substance Abuse History**

How often do you drink alcohol? <1x/week 1-2x/week 3-4x/week More than 4x/week (Hx?)

______________________________________________________________________

How often do you use or do you have a history of using marijuana heroin cocaine meth opiates <1x/week 1-2x/week 3-4x/week More than 4x/week

______________________________________________________________________

**Resources/Basic Needs** *Forward referral to Brenna for follow-up*

Do you need assistance with any of the following?

______Education *(Explain HSE services- forward referral to Brenna if interested)*

______Utilities/Internet/Cell phone service ______Housing ____Transportation ______Food

______Counseling ______Childcare ______Medical Insurance ______Immigration __Imagination Library

**Assign Home Visitor:**

________________________________Date ______________________

**Contact Dates** **Notes**

__________ ________________________________________

__________ ________________________________________

__________ ________________________________________