New Mexico
Early Childhood
Education & Care Department

Maternal-Child Health Information Form - Adult/Caregiver

Client ID	Name
Primary Language Spoken at Home: English ☐ Spanish ☐ Other ☐ ______________________	

Adult Participant/Caregiver

Please indicate (Yes, No, N/A) & Date for each Qtr. *Initial Qtr. Date* _______	*2nd Qtr.* *Date* _______	*3rd Qtr.* *Date* _______	*4th Qtr.* *Date* _______
Do you currently have a primary care provider? *Yes* ☐ *No* ☐ *N/A* ☐	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
If no, would you like a referral to a primary care provider? *Yes* ☐ *No* ☐ *N/A* ☐	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
Have you had continuous Health Insurance Coverage over the last 6 months? *Yes* ☐ *No* ☐ *N/A* ☐	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
Health insurance (check all that apply) ☐ No insurance coverage ☐ Private insurance/other ☐ Medicaid or CHIP ☐ Use Indian Health Services ☐ *Tricare (military)*	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change

Adult Participant/Caregiver Demographic

Initial Qtr. Date ______	2nd Qtr. Date ______	3rd Qtr. Date ______	4th Qtr. Date ______
Educational Status: ☐ *Currently enrolled in high school* ☐ *High school eligible, not enrolled* ☐ *Less than a high school diploma* ☐ *High school diploma* ☐ *GED* ☐ *Some college/technical training* ☐ *Technical training certificate* ☐ *Associate degree* ☐ *Bachelor's degree or higher* ☐ *Other*	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
Status in school ☐ *Student/trainee* ☐ *Not a student/trainee*	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
Employment ☐ *Employed part-time* ☐ *Employed full time* ☐ *Unemployed*	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
Marital status ☐ *Never married* ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed* ☐ *Cohabitant (not married)* ☐ *Unknown/did not report*	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
Housing status ☐ *Owns or shares ownership of home or apartment* ☐ *Rents or shares home or apartment* ☐ *Lives in public housing* ☐ *Lives with parent or family member* ☐ *Other living arrangements* ☐ *Homeless and sharing housing* ☐ *Homeless – emergency or transition* ☐ *Homeless – some other arrangement*	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change

Adult Participant/Caregiver Demographic

Please indicate (Yes, No, N/A) & Date for each Qtr. *Initial Qtr. Date ______*	*2nd Qtr.* *Date ______*	*3rd Qtr.* *Date ______*	*4th Qtr.* *Date ______*
Estimated annual family income from all sources: *$____________*	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
Family size: select the number from the choices *1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more ☐* ***Federal poverty level (see chart below)*** ☐ *100-133%* ☐ *201-250%* ☐ *134-138%* ☐ *251-300%* ☐ *139-150%* ☐ *301-400%* ☐ *151-200%*	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change

Click this link, Poverty Guidelines | ASPE (hhs.gov), to complete the section above.

Adult Parcipant/Caregiver Demographic

Please indicate (Yes, No, N/A) & Date for each Qtr. Initial Qtr. Date_______	2nd Qtr. Date_______	3rd Qtr. Date_______	4th Qtr. Date_______
High Needs Characteristics ☐ Teen parent ☐ Child with disabilities/chronic health ☐ Parent with disabilities/chronic health ☐ Parent with mental illness ☐ Low educational attainment ☐ Low income ☐ Recent immigrant or refugee family ☐ Substance abuse ☐ Court-appointed legal guardian/foster ☐ Homeless or unstable housing ☐ Incarcerated parent(s) ☐ Very low birth weight ☐ Death in the immediate family ☐ Domestic violence ☐ Child abuse or neglect ☐ Military family	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
☐ Are you worried about whether your food will run out before you have money to buy more?	☐ Often true ☐ Sometimes ☐ Never true	☐ Often true ☐ Sometimes ☐ Never true	☐ Often true ☐ Sometimes ☐ Never true
☐ Did the food you buy, not last, and you didn't have money to buy more?	☐ Often true ☐ Sometimes ☐ Never true	☐ Often true ☐ Sometimes ☐ Never true	☐ Often true ☐ Sometimes ☐ Never true
Please indicate (Yes, No, N/A) & Date for each Qtr. Initial Qtr. Date_______	**2nd Qtr. Date_______**	**3rd Qtr. Date_______**	**4th Qtr. Date_______**
Do you or any family members use tobacco products or e-cigarettes in the home? **Yes** ☐ **No** ☐ **N/A** ☐	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
If yes, would you like a referral for tobacco cessation counseling or other tobacco services? **Yes** ☐ **No** ☐ **N/A** ☐	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
Check the one that applies: ☐ Do not use tobacco, chew, or e-cig ☐ Less than 1 pack, chew, or e-cig ☐ 1 pack, chew, or e-cig ☐ 2 or more packs, chew, or e-cig	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
Check the one that describes the amount of alcohol consumption: ☐ Do not drink alcohol ☐ Less than one drink per day ☐ One drink per day ☐ More than one drink per day	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
If yes, would you like a referral for AA or other alcohol treatment supports? **Yes** ☐ **No** ☐ **N/A** ☐	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
Describe how you use recreational/illegal drugs (such as marijuana, cocaine, opiates, inhalants, etc.) ☐ Do not use drugs in any form ☐ Less than daily ☐ Daily one or more times	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
If yes, would you like a referral for substance abuse treatment? Yes ☐ **No** ☐ **N/A** ☐	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change

Prenatal Information

Please indicate (Yes, No, N/A) & Dates for each Qtr. *Initial Qtr. Date ________*		*2nd Qtr.* *Date ______*	*3rd Qtr.* *Date ______*	*4th Qtr.* *Date ______*
Are you currently pregnant? ***Yes*** ☐ ***No*** ☐ ***N/A*** ☐		☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
Estimated due date?	**Date:**			
Have you received prenatal care? ***Yes*** ☐ ***No*** ☐ ***N/A*** ☐ ***If yes, when did you start with prenatal care?*** ☐ **First trimester (0-3 months)** ☐ **Second trimester (4-6 months)** ☐ **Third trimester (7-9 months)**		☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
☐ ***Have you been diagnosed with hypertensive disorders?*** *(chronic hypertension, gestational hypertension, pre-eclampsia-eclampsia, chronic hypertension with superimposed pre-eclampsia)* ***Yes*** ☐ ***No*** ☐ ***N/A*** ☐		☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
Have you received the COVID-19 vaccine? ***Yes*** ☐ ***No*** ☐ ***N/A*** ☐		☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change

Postpartum Care

Please indicate (Yes, No, N/A) & Date for each Qtr. *Initial Qtr. Date ______*	*2nd Qtr. Date ______*	*3rd Qtr. Date ______*	*4th Qtr. Date ______*
☐ *During pregnancy, did you smoke any cigarettes, chew, or use e-cigs?* ☐ *During pregnancy, did you drink any alcohol?* ☐ *During pregnancy, did you use any recreational/ illegal drugs?* *Yes* ☐ *No* ☐ *N/A* ☐	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
If you used substances during pregnancy, when did you quit (date)? ______________	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
During pregnancy, did you experience any major events such as an accident or injury, or family challenges such as divorce/separation or a death in the family? *Yes* ☐ *No* ☐ *N/A* ☐	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
Did you have or do you plan to have a postpartum appointment scheduled? *Yes* ☐ *No* ☐ *N/A* ☐	☐ Change ☐ No change	☐ Change ☐ No change	☐ Change ☐ No change
If yes, what is/was the date of your post-partum visit?			