# Update Screening Questions

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ID**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Completed by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Administration:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Initial Enrollment Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**It is recommended that the program ask update screening questions to participants at least once near the end of each perinatal period.  If more frequent update screening is performed, the most recent data will overwrite prior responses and will be used to calculate performance measures.**

***ASK THESE UPDATE SCREENING QUESTIONS FOR EVERY PERINATAL PHASE: PRECONCEPTION, PRENATAL, POSTPARTUM AND INTERCONCEPTION/PARENTING:***

## Is there a place that you USUALLY go for care when you are sick or need advice about your health?

*Select one only*

* Yes
* No
* There is more than one place
* Don't know
* Declined to answer

## What kind of place do you go to most often when you are sick or you need advice about your health? Is it a doctor’s office, emergency room, hospital outpatient department, clinic or some other place?

*Select one answer.*

* Doctor’s Office
* Hospital Emergency Room
* Hospital Outpatient Department
* Clinic or Health Center
* Retail Store Clinic or “Minute Clinic”
* School (Nurse’s Office, Athletic Trainer’s Office)
* Some other place
* Don’t know
* Declined to answer

## Please tell me what kind of health insurance you have:

*Select all that apply.*

* Private health insurance through my job, or the job of my husband, partner or parents
* Insurance purchased directly from an insurance company
* Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability
* TRICARE or other military health care
* Indian Health Service
* Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No insurance
* Don’t know
* Declined to answer

## Over the past two weeks, how often have you experienced any of the following, would you say, never, several days, more than half the days, or nearly every day?

***STAFF: Read each problem to participant, and enter one score for each question.***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Q#** | **Problem** | **Not at all** | **Several Days** | **More than half the days** | **Nearly every day** | **Score** |
|  | Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |  |
|  | Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |  |
|  | Total Score |  |  |  |  |  |

**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 3, further assessment is needed.

## We are concerned about the safety of all participants. Please answer the following questions about experiences that you may have had during the past 12 months so that we can help you if needed.

***STAFF: Please read each question to participant and enter one response for each question.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Q#** | **During the past 12 months…** | **Yes** | **No** | **Declined to Answer** |
|  | Did your husband or partner threaten or make you feel unsafe in some way? |  |  |  |
|  | Were you frightened for your safety or your family’s safety because of the anger or threats of your husband or partner? |  |  |  |
|  | Did your husband or partner try to control your daily activities, for example, control who you could talk to or where you could go? |  |  |  |
|  | Did your husband or partner push, hit, slap, kick, choke, or physically hurt you in any other way? |  |  |  |
|  | Did your husband or partner force you to take part in touching or any sexual activity when you did not want to? |  |  |  |
|  | Did anyone else physically hurt you in any way? |  |  |  |

# Preconception

***IN ADDITION TO UPDATE SCREENING QUESTIONS FOR EACH PERINATAL PHASE, THIS UPDATE SCREENING QUESTION SHOULD BE ASKED OF PARTICIPANTS IN THE PRECONCEPTION PHASE:***

## 17. 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?

* Yes
* No
* Don't know
* Declined to Answer

# Prenatal

***IN ADDITION TO UPDATE SCREENING QUESTIONS FOR EACH PERINATAL PHASE, THE FOLLOWING TWO UPDATE SCREENING QUESTION SHOULD BE ASKED OF PARTICIPANTS IN THE PRENATAL PHASE:***

## 7. 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 number of weeks OR number of months.***

\_\_\_\_\_ Weeks OR \_\_\_\_\_\_ Months

* Don’t know
* Declined to answer
* I didn’t go for prenatal care

## 49. Would you describe your partner or the father of this baby as:

*Select only one*.

***STAFF: Please read responses to participant***.

* Involved in my pregnancy and supportive of me
* Involved but not supportive of me
* Aware that I’m pregnant but not involved
* Not aware that I’m pregnant

**DO NOT READ OUT LOUD**

* Declined to answer

# Postpartum

***IN ADDITION TO UPDATE SCREENING QUESTIONS FOR EACH PERINATAL PHASE, THE FOLLOWING UPDATE SCREENING QUESTION SHOULD BE ASKED OF PARTICIPANTS IN THE POSTPARTUM PHASE:***

## Good sleep habits are important to your baby’s/babies’ 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.

## 5. In which one position do you most often lie your baby/babies down to sleep now?

***STAFF: Please read responses to participant. Select one response only for each baby.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **On his or her side**  | **On his or her back**  | **On his or her stomach**  | **Declined to answer**  |
| **Baby 1** |  |  |  |  |
| **Baby 2** |  |  |  |  |
| **Baby 3** |  |  |  |  |
| **Baby 4** |  |  |  |  |

*

## 6. In the past 2 weeks, how often has your new baby/have your new babies slept alone in his or her/their own crib or bed? Would you say always, often, sometimes, rarely, or never?

*Select one response only for each baby.*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Responses** | **Always** | **Often** | **Sometimes** | **Rarely** | **Never** | **Don’t know** | **Declined to answer** |
| **Baby 1** |  |  |  |  |  |  |  |
| **Baby 2** |  |  |  |  |  |  |  |
| **Baby 3** |  |  |  |  |  |  |  |
| **Baby 4** |  |  |  |  |  |  |  |

## 7. Please tell us how your new baby/ babies most often slept in the past 2 weeks.

## STAFF: PLEASE READ each sleeping location to participant and select a response for each sleeping location for each baby.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sleeping Location** | **Baby 1** | **Baby 2** | **Baby 3** | **Baby 4** |
| In a crib, bassinet, or pack and play |  |  |  |  |
| On a twin or larger mattress or bed |  |  |  |  |
| On a couch, sofa, or armchair |  |  |  |  |
| In an infant car seat or swing |  |  |  |  |
| With a blanket |  |  |  |  |
| With toys, cushions, or pillows, including nursing pillows |  |  |  |  |
| With crib bumper pads (mesh or non-mesh |  |  |  |  |
| In a sleeping sack or wearable blanket |  |  |  |  |

## 11. Is there a place that your baby/babies USUALLY goes/go for care when he or she is sick or when you or another caregiver need advice about your baby’s health?

*Select one response only for each baby.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **There is more than one place** | **Don’t Know** | **Declined to Answer** |
| **Baby 1** |  |  |  |  |  |
| **Baby 2** |  |  |  |  |  |
| **Baby 3** |  |  |  |  |  |
| **Baby 4** |  |  |  |  |  |

## If baby has/babies have one or more usual place for care, go to question 11.1

## If baby has/babies have no usual place, don’t know, or declined to answer, go to question 12.

## 11.1 What kind of place does your baby/ do your babies go to most often when he/she is sick or you need advice about his/her health? Is it a doctor’s office, emergency room, hospital outpatient department, clinic or some other place?

*Select one only for each baby.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Baby 1** | **Baby 2** | **Baby 3** | **Baby 4** |
| Doctor’s Office |  |  |  |  |
| Hospital Emergency Room |  |  |  |  |
| Hospital Outpatient Department |  |  |  |  |
| Clinic or Health Center |  |  |  |  |
| Retail Store Clinic or “Minute Clinic |  |  |  |  |
| School (Nurse’s Office, Athletic Trainer’s Office) |  |  |  |  |
| Some other place |  |  |  |  |
| Don’t know |  |  |  |  |
| Declined to answer |  |  |  |  |

## 12. When was your baby's/babies’ last visit to a doctor, nurse, or other health provider for a well-child check-up? Select one response only for each child.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Date of baby’s last visit** | **Don’t know** | **Declined to answer** |
| **Baby 1** | \_\_ / \_\_ / \_\_\_\_ |  |  |
| **Baby 2** | \_\_ / \_\_ / \_\_\_\_ |  |  |
| **Baby 3** | \_\_ / \_\_ / \_\_\_\_ |  |  |
| **Baby 4** | \_\_ / \_\_ / \_\_\_\_ |  |  |

## 13. Please tell me what kind of health insurance your baby has/babies have:

*Select all that apply for each baby.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Baby 1** | **Baby 2** | **Baby 3** | **Baby 4** |
| Private health insurance through my job, or the job of my husband, partner or parents |  |  |  |  |
| Insurance purchased directly from an insurance company |  |  |  |  |
| Medicaid, Medical Assistance, or any kind of government assistance plan for those with low incomes or a disability |  |  |  |  |
| TRICARE or other military health care |  |  |  |  |
| Indian Health Service |  |  |  |  |
| Other, specify |  |  |  |  |
| No insurance |  |  |  |  |
| Don’t know |  |  |  |  |
| Declined to answer |  |  |  |  |

## 33. Since your child was /children were born, have you had a postpartum visit for yourself? A postpartum visit is the regular checkup a woman has 4-6 weeks after she gives birth.

*Select one only.*

* Yes (Go to question 33.1)
* No (Go to question 33.2)
* Don't know (Go to question 33.2)
* Declined to answer (Go to question 33.2)

## 33.1 When did you have your postpartum visit?

**STAFF: Please enter day of postpartum visit.**

\_\_ / \_\_ / \_\_\_\_ (month/day/year)

* Have not had a postpartum visit [if none, go to question 33.2]

## 33.2 Do you have one scheduled?

 *Select one only.*

* Yes: Please indicate date of scheduled appointment: \_\_\_ / \_\_ / \_\_\_\_ (month/day/year)
* No
* Declined to answer

## 50. Would you describe your partner or the father of your baby/babies as:

***STAFF: Please read responses to participant, and select only one response.***

* Involved and supportive of me and my baby/babies
* Involved but not supportive of me or my baby/babies
* Not involved

**Staff: DO NOT READ OUT LOUD:**

* Declined to answer

# Interconception/Parenting

***IN ADDITION TO UPDATE SCREENING QUESTIONS FOR EACH PERINATAL PHASE, THE FOLLOWING UPDATE SCREENING QUESTION SHOULD BE ASKED OF PARTICIPANTS IN THE INTERCONCEPTION/PARENTING PHASE:***

***2. Did you ever breast feed or pump breast milk to feed your child/children after delivery, even for a short period of time?***

*Select one only for each child.*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes** | **No** | **Declined to answer** |
| **Child 1** |  |  |  |
| **Child 2** |  |  |  |
| **Child 3** |  |  |  |
| **Child 4** |  |  |  |

**STAFF: If any children were breastfed, go to question 2.1**

**If participant responded “no” or declined to answer for all children, go to question 3.**

***2.1 How many days, weeks or months did you breastfeed or pump breast milk for your child/children?***

***STAFF: Please write in the number provided by the participant and enter number of days, weeks OR months for each child.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Number of days, weeks or months (record number and circle appropriate time period)** | **Still/Currently breastfeeding** | **Don’t know** | **Declined to answer** |
| **Child 1** |  Days Weeks \_\_\_\_\_\_\_\_ Months |  |  |  |
| **Child 2** |  Days Weeks \_\_\_\_\_\_\_\_ Months |  |  |  |
| **Child 3** |  Days Weeks \_\_\_\_\_\_\_\_ Months |  |  |  |
| **Child 4** |  Days Weeks \_\_\_\_\_\_\_\_ Months  |  |  |  |

## 3. Please 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: Record the total number of days, from 0 days (no days) to 7 days (everyday**).

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Days per week (Record the number)** | **Don’t know** | **Declined to answer** |
| **Child 1** |  |  |  |
| **Child 2** |  |  |  |
| **Child 3** |  |  |  |
| **Child 4** |  |  |  |

***Good sleep habits are important to your child’s physical health and emotional well-being. An important part of safe sleep is the place where your child sleeps, his sleeping position, the kind of crib or bed, and type of mattress.***

***STAFF: Ask questions 5, 6, 7 about safe sleep for children less than 12 months old only.***

***5. In which one position do you most often lie your baby/babies down to sleep now?***

***STAFF: Please read responses to participant. Select one response only for each child.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **On his or her side**  | **On his or her back**  | **On his or her stomach**  | **Declined to answer**  |
| Child 1 |  |  |  |  |
| Child 2 |  |  |  |  |
| Child 3 |  |  |  |  |
| Child 4 |  |  |  |  |

***6. In the past 2 weeks, how often has your new child/have your new children slept alone in his or her/their own crib or bed? Would you say always, often, sometimes, rarely, or never?***

*Select one response only for each child.*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Always** | **Often** | **Sometimes** | **Rarely** | **Never** | **Don’t know** | **Declined to answer** |
| **Child 1** |  |  |  |  |  |  |  |
| **Child 2** |  |  |  |  |  |  |  |
| **Child 3** |  |  |  |  |  |  |  |
| **Child 4** |  |  |  |  |  |  |  |

***7. Please tell us how your child/children most often slept in the past 2 weeks.
STAFF: PLEASE READ each sleeping location to participant and select a response for each sleeping location for each child.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Sleeping Location** | **Child 1** | **Child 2** | **Child 3** | **Child 4** |
| In a crib, bassinet, or pack and play |  |  |  |  |
| On a twin or larger mattress or bed |  |  |  |  |
| On a couch, sofa, or armchair |  |  |  |  |
| In an infant car seat or swing |  |  |  |  |
| With a blanket |  |  |  |  |
| With toys, cushions, or pillows, including nursing pillows |  |  |  |  |
| With crib bumper pads (mesh or non-mesh |  |  |  |  |
| In a sleeping sack or wearable blanket |  |  |  |  |

***13. Is there a place that your child USUALLY goes for care when he or she is sick or when you or another caregiver need advice about your child’s health?***

*Select one response only for each child.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** | **There is more than one place** | **Don’t Know** | **Declined to Answer** |
| **Child 1** |  |  |  |  |  |
| **Child 2** |  |  |  |  |  |
| **Child 3** |  |  |  |  |  |
| **Child 4** |  |  |  |  |  |

***If child has/children have one or more usual place for care, go to question 13.1***

***If child has/children have no usual place, don’t know, or declined to answer, go to question 14.***

***13.1. What kind of place does your child go to most often when he or she is sick or you need advice about his or her health? Is it a doctor’s office, emergency room, hospital outpatient department, clinic or some other place?***

*Select one response only for each child.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Child 1** | **Child 2** | **Child 3** | **Child 4** |
| Doctor’s Office |  |  |  |  |
| Hospital Emergency Room |  |  |  |  |
| Hospital Outpatient Department |  |  |  |  |
| Clinic or Health Center |  |  |  |  |
| Retail Store Clinic or “Minute Clinic” |  |  |  |  |
| School (Nurse’s Office, Athletic Trainer’s Office) |  |  |  |  |
| Some other place |  |  |  |  |
| Don’t know |  |  |  |  |
| Declined to answer |  |  |  |  |

## 15. When was your child's last visit to a doctor, nurse, or other health provider for a well-child check-up?

*Select one response only for each child.*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Date of child’s last visit** | **Don’t know** | **Declined to answer** |
| **Child 1** | \_\_ / \_\_ / \_\_\_\_ |  |  |
| **Child 2** | \_\_ / \_\_ / \_\_\_\_ |  |  |
| **Child 3** | \_\_ / \_\_ / \_\_\_\_ |  |  |
| **Child 4** | \_\_ / \_\_ / \_\_\_\_ |  |  |

## 36. 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?

* Yes
* No
* Don't know
* Declined to Answer

## 59. Would you describe your partner or the father of your child/children as:

**STAFF: Please read responses to participant, and select only one response.**

* Involved and supportive of me and my child/children
* Involved but not supportive of me or my child/children
* Not involved

**Staff: DO NOT READ OUT LOUD:**

* Declined to answer