Nurse-Family Partnership
Helping First-Time Parents Succeed.

Demographics: Pregnancy – Intake

Client ID ______ Client Name ______ DOB ______
Client SSN ______
Date ______ Nurse Home Visitor ID ______ Nurse Home Visitor Name ______

Section I - Personal/Family – This section is to be entered into the View/Edit Client Demographics screen in ETO.

1. ♦Client's DOB: ____________________

2. ♦Ethnicity (check one):
   - ☐ Hispanic or Latina
   - ☐ Not Hispanic or Latina
   - ☐ Declined to self-identify

3. ♦Race (check all that apply)
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African-American
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ White
   - ☐ Declined to self-identify

4. Client's Ancestry (check all that apply):
   - ☐ Afro-Caribbean, excluding Haitian
   - ☐ Anglo-Dutch Caribbean
   - ☐ Arab
   - ☐ Bangladeshi/Bengali
   - ☐ Central American, including Mexican
   - ☐ Chinese
   - ☐ Cuban
   - ☐ Dominican
   - ☐ Eritrean
   - ☐ Filipino
   - ☐ Haitian
   - ☐ Hmong
   - ☐ Indian (South Asian)
   - ☐ Israeli
   - ☐ Other (please specify)________________
   - ☐ Korean
   - ☐ Laotian
   - ☐ North African
   - ☐ Pakistani
   - ☐ Palestinian
   - ☐ Persian
   - ☐ Polish
   - ☐ Puerto Rican
   - ☐ Russian
   - ☐ Somali
   - ☐ Sub-Saharan African
   - ☐ South American
   - ☐ Ukrainian
   - ☐ Vietnamese

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5. ♦Client's Primary Language (check only one):

- ☐ English
- ☐ Spanish
- ☐ Arabic
- ☐ Cantonese
- ☐ Creole (Haitian)
- ☐ French
- ☐ Hindi
- ☐ Italian
- ☐ Japanese
- ☐ Korean
- ☐ Mandarin
- ☐ Polish
- ☐ Russian
- ☐ Tagalog
- ☐ Tribal Languages
- ☐ Vietnamese
- ☐ Other (please specify)__________

6. ♦ Client's Zip Code: ________________

Section II – Other Demographics

1. ♦Are you participating in this program voluntarily?
   - ☐ Yes
   - ☐ No

2. ♦Marital Status:
   - ☐ Married (legal or common law)
   - ☐ Single - never married
   - ☐ Widowed
   - ☐ Divorced
   - ☐ Separated
   - ☐ Not Married – living with partner

3. ♦How often do you usually see or talk to the baby's biological father?
   - ☐ Not at all
   - ☐ Less than once a week
   - ☐ At least once a week but not daily
   - ☐ Daily

4. ♦With whom do you live? (check only one from options 1 – 5)
   - ☐ Live with others (check all that apply)
     - ☐ Client's mother
     - ☐ Father of Child (FoC)
     - ☐ Current husband/partner (not FoC)
     - ☐ Other family members
     - ☐ Infant/child
     - ☐ Other adults
   - ☐ Live alone (or with infant/child)
   - ☐ Live in a group home/shelter
   - ☐ Confined to an institutional facility (residential treatment facility, incarcerated)
   - ☐ Homeless

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☐ Homeless and sharing housing (skip to 6)
☐ Homeless and living in emergency or transitional shelter (skip to 6)
☐ Other (skip to 6)

5. ♦ If you are not homeless, where do you currently live?
☐ Owns or shares own home, condominium, or apartment
☐ Rents or shares own home or apartment
☐ Lives in public housing
☐ Lives with parent or family member
☐ Other

6. ♦ Which members of your family are in the Military – active or reserve? (check all that apply)
☐ Self (client)
☐ Client's spouse
☐ Client's parent(s)
☐ Father of child (FoC)
☐ None

Section III – Education and Income

7. ♦ Are you currently enrolled in middle or high school?
☐ Yes – middle school (6th – 8th grades)
☐ Yes – high school or GED program (includes alternative and technical programs)
☐ Not enrolled

8. ♦ Have you completed high school or a GED or vocational/certification program?
☐ Yes - completed high school
☐ Yes - completed GED
☐ Yes - completed vocational/certification program
☐ No. If no, what is the last grade you have <u>completed</u>? ☐ grade (skip to 12)

9. ♦ If you have completed high school/GED, are you currently enrolled in any kind of school, vocational, certification or educational program?
☐ Yes
  ☐ Full Time – 12 semester hours or equivalent
  ☐ Part Time
    ☐ 7 – 11 semester hours or equivalent
    ☐ 6 or less semester hours or equivalent
☐ No (skip to 11)

10. ♦ What type of educational program are you currently enrolled in?
☐ Post-high school vocational/certification/technical training
☐ College

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11. ♦Have you completed education other than high school/GED (mark the highest level)?

- ☐ Vocational/certification/technical training program (beyond high school)
- ☐ Some college (no degree)
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Professional degree (for example: LLB, LD, MD, DDS)
- ☐ Doctorate degree (for example: PhD, EdD)
- ☐ No

12. ♦Do you **have a** plan to enroll in any ***additional*** kind of school, vocational, certification or educational program?

- ☐ Yes
- ☐ No

13. ♦Are you currently working?

- ☐ Yes
  - ☐ Full-time: 37+ hours per week
  - ☐ Part-time
    - ☐ 20 – 36 hours per week
    - ☐ 10 – 19 hours per week
    - ☐ less than 10 hours per week
- ☐ No
  - ☐ Unemployed and seeking employment
  - ☐ Not employed (student, homemaker, other)

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14. ♦Which of the following categories best describes your <u>total</u> yearly household income and types of benefits you receive? Include your income and any other income you may have received. For the purpose of this question, the household should include only you and your child. Remember that this information will be kept private and will not affect your access to services (Use public assistance programs that are for low-income families as a marker if the client does not know and she qualifies or receives a public assistance program).

Sources of household income include (please check all that apply)

- ☐ Salary/wages from employment
- ☐ Social Security/Disability
- ☐ TANF
- ☐ Alimony
- ☐ Child Support
- ☐ Rent from tenants
- ☐ Cash Assistance from friends/relatives
- ☐ Unemployment
- ☐ Other income (please specify)________________

- ☐ Less than or equal to $6,000
- ☐ $6,001 - $9,000
- ☐ $9,001 - $12,000
- ☐ $12,001 - $16,000
- ☐ $16,001 - $20,000
- ☐ $20,001 - $30,000
- ☐ Over $30,000
- ☐ Client is dependent on parent/guardian

15. ♦Do you (client) qualify for TANF, Medicaid, WIC or Foodstamps?

- ☐ Yes
- ☐ No

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16. ♦In the past 6 months, have you (client) obtained care at the hospital emergency room for any reason?

☐ Yes

If yes, what was the purpose of the visit (please check all that apply)?

- ☐ Injury – Accidental, how many times? ☐ times
- ☐ Injury – Intentional self inflicted, how many times? ☐ times
- ☐ Injury – Intentional other inflicted, how many times? ☐ times
- ☐ Injury – Declined how many times? ☐ times
- ☐ Ingestion – Accidental, how many times? ☐ times
- ☐ Ingestion – Intentional self inflicted, how many times? ☐ times
- ☐ Ingestion – Intentional other inflicted, how many times? ☐ times
- ☐ Ingestion – Declined, how many times? ☐ times
- ☐ Respiratory infection, how many times? ☐ times
- ☐ Fever, how many times? ☐ times
- ☐ Other (please specify)________________, how many times? ☐ times

☐ No

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17. ♦In the past 6 months, have you (client) obtained care at the urgent care center for any reason?

- ☐ Yes

  If yes, what was the purpose of the visit (please check all that apply)?

  - ☐ Injury – Accidental, how many times? ☐ times
  - ☐ Injury – Intentional self inflicted, how many times? ☐ times
  - ☐ Injury – Intentional other inflicted, how many times? ☐ times
  - ☐ Injury – Declined, how many times? ☐ times
  - ☐ Ingestion – Accidental, how many times? ☐ times
  - ☐ Ingestion – Intentional self inflicted, how many times? ☐ times
  - ☐ Ingestion – Intentional other inflicted, how many times? ☐ times
  - ☐ Ingestion – Declined, how many times? ☐ times
  - ☐ Respiratory infection, how many times? ☐ times
  - ☐ Fever, how many times? ☐ times
  - ☐ Other (please specify)_______________, how many times? ☐ times
- ☐ No

18. ♦Do you (client) have health insurance coverage?

- ☐ Yes
- ☐ No

If yes, which type of health insurance do you use when you go for medical care? (please check all that apply)?

- ☐ Medicaid
- ☐ CHIP
- ☐ Tri-Care
- ☐ Private
- ☐ Other (please specify)_______________

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