Nurse-Family Partnership
Helping First-Time Parents Succeed

Infant Birth

Infant ID		Infant Name		♦Infant DOB*	
Client ID		Client Name		DOB	
Date		Nurse Home Visitor ID		Nurse Home Visitor Name	

***Infant DOB to be entered into the View/Edit Client Demographics screen in ETO.**

Multiple birth ☐

1. Child's Ethnicity (check one):
   - ☐ Hispanic or Latina/Latino
   - ☐ Not Hispanic or Latina/Latino

2. Child's Race (check all that apply)
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African-American
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ White

3. Gender:
   - ☐ Male
   - ☐ Female

4. Birth weight: ☐ grams or ☐ lbs. ☐ oz.

5. ♦Gestational age at birth: ☐ weeks

6. ♦Was (child's name) admitted to the NICU because of problems?
   - ☐ Yes, for how many days prior to being discharged? ☐ days
   - ☐ No. If no, did (child's name) have to spend any time in the special care nursery because of problems?
     - ☐ Yes, for how many days prior to being discharged? ☐ days
     - ☐ No

   If yes, what was the purpose of the stay (please check all that apply)?
     - ☐ Low birth weight
     - ☐ Very low birth weight
     - ☐ Respiratory distress
     - ☐ Prematurity
     - ☐ Congenital defect
     - ☐ Other (please specify)________________

7. ♦What was your overall weight gain during pregnancy? ☐ lbs.

8. ♦Has your baby ever received breast milk?
   - ☐ Yes
   - ☐ No

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9. ♦Type of labor
   - ☐ Induced
   - ☐ Not induced

10. ♦Type of delivery
    - ☐ Vaginal
    - ☐ Caesarean

11. ♦Did your child receive a newborn screening test in the nursery?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

12. ♦Did your child receive a hearing screening in the nursery?
    - ☐ Yes
    - ☐ No
    - ☐ Don't know

13. ♦How often do you place your infant to sleep on their back?
    - ☐ Always
    - ☐ Sometimes
    - ☐ Never

14. ♦How often do you bed-share with your infant?
    - ☐ Always
    - ☐ Sometimes
    - ☐ Never

15. ♦How often does your infant sleep with soft bedding?
    - ☐ Always
    - ☐ Sometimes
    - ☐ Never

16. ♦During a typical week, how many days do you (and/or a family member) read, tell stories, and/or sing songs to your child?

    ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

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Revised October 2016

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17. ♦Does your child have health insurance coverage?
    - ☐ Yes
    - ☐ No

    If yes, which type of health insurance do you use when you take your child for medical care (please check all that apply)?
    - ☐ Medicaid
    - ☐ CHIP
    - ☐ Tri-Care
    - ☐ Private
    - ☐ Other (please specify)_______________

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