



Healthy Start Infant/Child Initial Assessment

Family/Home

Ask the child's parent/guardian what they feel are the family's assets, strengths and resources.

Ex: "What is working well for your family now? What are some of the positive things in your family's life?" Note below.

Family Assets, Strengths, and Resources

Ask the child's parent/guardian "What are the family's main concerns now that they have a young child?"
"Is there anything that is a worry right now?" Note below.

Family Concerns

Through your discussion with the child's parent, please determine nutritional practices of the participant. Note below.

Nutritional Assessment

- Receiving WIC
- Food allergies
- Raw or undercooked meats/seafood consumed
- Dietary supplements
- Type of feeding (breast, bottle, combination, or tube feeding; solid foods)
-If bottle-feeding or tube feeding, type of formula; amount at each feeding.
- Feeding frequency
- Cereal in bottle
- Juice in bottle
- Drinking from cup
- Age started solids
- Types of solids
-Type and amount of solids consumed daily
- Nutrition-related medical conditions
- Ethnic supplements

Ask the child's parent/guardian what prescribed medications or over the counter medications, the participant is currently taking, and how often. Please note below.

Medication/Supplements

- Vitamins/ iron _____
- Medications (prescription and over the counter) _____
- Herbal _____
- Supplements _____
- Other _____



Through interview, if face to face visit is in the community, or observation, if face to face visit is in the participant's home, assess the presence of the following items, household or conditions in the participant's home. Please note.

Household Assessment

Exterior household status: adequately maintained ____ needs maintenance ____
 Interior household status (clean, dirty, cluttered, smoky, crowded, hectic, safe, unsafe, unsanitary, malodorous) ____
 Excluding participant, number of adult household members ____
 Excluding participant, number of child (under age 18) household members ____
 Excluding participant, number of non-family household members ____
 Current living situation (owns, rents, lives with boyfriend/family, halfway home, homeless, other) ____
 Type of residence (house, apartment, townhouse, government funded, mobile home, other) ____
 Number of bedrooms ____

- Toilet facilities
- Household clean/tidy
- Safe infant sleeping arrangement
- Pets (cats, dogs, reptiles, rabbits, birds, livestock, other)
- Vermin
- Lead hazards
- Unsafe conditions (of house, in household)
- Other

Non-functioning items in the household

- Phone
- Smoke Detector
- Running Water
- Air Conditioner/Fan
- Heat
- Refrigerator
- Stove

Ask the child's parent/guardian if the participant has any interactions with a day care setting, mold in the household, any exposure to second hand smoke, exposure to cat litter, or any other environmental item that could cause a potential illness or risk to the participant. Please note below.

Current Exposures

- Child Care/Day Care exposure
- Mold
- Cat litter
- Second hand smoke
- Other

Please note your observation of the interaction between the parent/guardian and child below.

Parent (or Guardian)/Child Interaction

- Appears to enjoy caring for baby
- Talks to child in warm, positive tone
- Responds promptly and calmly to crying
- Interprets infant cues correctly
- Holds child close, touches child to comfort
- Sings or reads to child
- Positions on stomach to play
- Positions child on back to sleep
- Provides consistent routines for eating, sleeping
- Other

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 ID No:
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Through your discussion with child's parent/guardian, please review for any occupational/lifestyle risks. Please check below.

Child's parent/guardian occupational/lifestyle risk

- Attending School
-Level of education completed (less than high school, high school, vocational, community college, university)
- Employed yes _____ no _____ stay at home mom _____ unable to work due to disability _____
-Type of employment (full time, part time, both)
-Length of employment
-Type of work
- Job stress low _____ medium _____ high _____ none _____

Physical/Psychosocial Assessment

Using your observation and interviewing skills, check below your assessment of parent/guardian and child. Define in comments.

Child's Physical and Psychosocial Assessment

Child's age at time of initial assessment _____ Child's birth weight _____ Child's gestational age _____

- Age appropriate interaction with others
- Alert/awake
- Anxious, fearful
- Appropriately dressed, clean
- Confusion, displays lack of understanding
- Coos/babbles
- Cuts and bruises
- Disability
- Drowsy
- Irritable, angry, tense
- Jaundiced
- Quiet (withdrawn, not talkative, reserved)
- Restless/agitated
- Sleeping
- Swelling
- Tearful, sad
- Unkempt, dirty
- Other

Parent's or Guardian's Physical and Psychosocial Assessment

- Friendly (talkative, easily engaged in conversation)
- Quiet (withdrawn, not talkative, reserved)
- Alert/awake
- Drowsy
- Cooperative
- Uncooperative
- Limited coping skills (overwhelmed by problems)
- Confusion, displays lack of understanding
- Appropriately dressed, clean
- Unkempt, dirty
- Restless/agitated



- Shaking/tremors
- Unable to focus, difficulty concentrating, scattered thoughts
- Tearful, sad
- Irritable, angry, tense
- Anxious, fearful
- Swelling
- Cuts and bruises
- Self reported history of mental health diagnosis
- Disability
- Other

Risks/Needs/Referrals

Please check below any risk factors identified through the initial assessment process. These risk factors would be in addition to those previously determined through the initial contact process. New risk factors identified since initial contact? Yes _____ No _____

Risk Factors

- Anxiety
- Household Violence
- Lack of Car Seat
- Medical Condition
- Parent / Guardian does not hold child close or touch child to comfort
- Sadness
- Second-hand Smoke
- Transportation Barriers
- Unsafe Sleep Environment for infant
- Other
- Above checked risk factors discussed with parent/guardian? (Y/N drop down)

Through your discussion with the child’s parent/guardian, please determine any current needs of the participant and family. Check below, along with indicating any referrals provided.

New needs identified since initial contact? Yes _____ No _____

<u>Needs Identified</u>	<u>Referrals Provided</u>	<u>Education Provided</u>
<input type="checkbox"/> Food	_____	_____
<input type="checkbox"/> Psychosocial/Mental health services	_____	_____
<input type="checkbox"/> Parenting education	_____	_____
<input type="checkbox"/> Childbirth education	_____	_____
<input type="checkbox"/> Nutrition education	_____	_____
<input type="checkbox"/> Shelter	_____	_____
<input type="checkbox"/> Clothing	_____	_____
<input type="checkbox"/> General supplies	_____	_____
<input type="checkbox"/> School	_____	_____
<input type="checkbox"/> Employment	_____	_____
<input type="checkbox"/> Financial assistance	_____	_____
<input type="checkbox"/> Transportation	_____	_____
<input type="checkbox"/> Access to Services	_____	_____
<input type="checkbox"/> Healthcare Coverage	_____	_____
<input type="checkbox"/> Medical	_____	_____

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- Dental _____
- Daycare resources _____
- Baby supplies _____
- Social support _____
- Access to Family Planning _____
- Smoking cessation _____
- Substance abuse treatment _____
- Household Violence Information _____
- Other _____

Evaluation/Summary

(Health education components below will be on a drop down in HMS for selection)

Health Education Provided

- Baby Spacing/Family Planning
- Breastfeeding
- Disaster/Safety Planning
- Immunizations
- Infant Care
- Medicaid Family Planning Waiver
- Nutrition
- Parenting
- Safe Sleep Environment
- Secondhand Smoke
- Shaken Baby Prevention
- SIDS Risk Reduction
- Other (text box)

Care Coordination Details

Method of Initial Assessment: Home Visit _____ Other Face-to-Face Encounter _____
 Client level today _____
 Plan of care evaluated today? _____
 Plan of care changed today? (text box) _____
 Follow-up with provider completed on (date) ____ by _____
 Follow-up with provider completed by (method)? Letter _____ Phone _____

Overall Assessment Summary

Signature: _____

Date: _____

Authenticate: _____

Date: _____

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