Community Colleges of Spokane

Spokane County Head Start/ECEAP/EHS
PREGNANCY ENROLLMENT INFORMATION

1. Enrollee's Name: Last: ______________________ First: ______________________
2. Do you have medical coverage for this pregnancy? ☐ Yes ☐ No
   If yes, what type of coverage? ☐ Medicaid, EPSDT or equivalent ☐ Private insurance
   Name of provider: ______________________ ID or Policy Number: ______________
3. Is dental coverage included? ☐ Yes ☐ No
4. How long have you been pregnant? ☐ Less than 12 weeks ☐ 12-24 weeks ☐ More than 24 weeks
5. What is your expected delivery date? ______________________
6. Have you received any prenatal care? ☐ Yes ☐ No
   If yes, where did you receive prenatal care? *(check all that apply)*
   ☐ Health Clinic ☐ Private Physician
   ☐ Hospital ☐ School-based health facility
   ☐ In enrollee's home ☐ Other, specify: ______________________
7. Do you have a primary health care provider? ☐ Yes ☐ No
   If yes, Name: ______________ Address: ______________ Phone: __________
8. Do you have a prenatal care provider? ☐ Yes ☐ No
   If yes, Name: ______________ Address: ______________ Phone: __________
9. Do you have a dental care provider? ☐ Yes ☐ No
   If yes, Name: ______________ Address: ______________ Phone: __________
10. In which month of pregnancy did you see a doctor or clinic for prenatal care?
    ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th ☐ 9th
11. What is the date of recent prenatal care visit? ______________(if none enter '0')
12. What is the date of your next scheduled prenatal visit? ______________(if none enter '0')
13. How many prenatal care visits have you had since the first visit (not counting the first visit)?
    ☐ No visits beyond the 1 ☐ one ☐ two ☐ three ☐ four ☐ five
    ☐ six ☐ seven ☐ eight ☐ nine+ ☐ do not remember

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14. What complications have you experienced during this and any previous pregnancies? (Read list and check all that apply)

	Previous Pregnancies	Current Pregnancies
No complications experienced	☐	☐
Pain	☐	☐
Headaches	☐	☐
Hypertension	☐	☐
Irritability	☐	☐
Anxiety / Stress	☐	☐
Swelling	☐	☐
Fatigue	☐	☐
Bleeding	☐	☐
Anemia (Hgb, 10 or Hct., 30)	☐	☐
Sickle Cell Anemia	☐	☐
Diabetes (insulin dependent)	☐	☐
Pregnancy-induced Hypertension	☐	☐
Low birth weight, specify weight: ____________________	☐	☐
Pre-term labor	☐	☐
Neonatal death (28 days)	☐	☐
C-section	☐	☐
Other, specify: ____________________	☐	☐

15. Did any of these complications require bed rest or hospitalization? ☐ Yes ☐ No

If yes, which complications? ____________________ For how many days? ____________

16. How many times have you been pregnant prior to this pregnancy? ____________________

17. How many children have you given birth to? ____________________

18. If the number is different between number of pregnancies and number of births, what was the outcome of those other pregnancies? *(Check all that apply)*

☐ Multiple birth ☐ Stillborn ☐ Other? Specify ____________________

☐ Miscarriage ☐ Abortion ☐ Refused

19. How many of your children were born prematurely? (i.e., less than 5 lbs **or** less than 7 mos) ____________

20. How long has it been since your last pregnancy?

☐ Never been pregnant before ☐ Less than 18 months ☐ More than 18 months

21. What medical or health services are you currently receiving? *(Read list and check all that apply)*

☐ Medical Assistance / Medicaid / SCHIP Since: ____________________

☐ WIC / Other Nutritional Services Since: ____________________

☐ Substance Abuse Treatment Since: ____________________

☐ Mental Health Counseling / Treatment Since: ____________________

☐ Other Services, specify Since: ____________________

☐ No services currently received

22. Have you participated in any support or educational groups for pregnancy, child birth or parenting during your current pregnancy? ☐ Yes ☐ No

If yes, what kind of groups have you participated in? *(Check all that apply)*

☐ Prenatal Exercise ☐ Prenatal General Discussion ☐ Birth Education (i.e., Lamaze)

☐ Breast Feeding Preparation ☐ Preparing for Baby Care ☐ Personal Development

☐ Parenting Education ☐ Other ______________________

23. How many sessions of these pregnancy, birth or parenting groups have you attended?

☐ 1-5 ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 30+

24. Have you been visited regularly by any nurse, social worker, school support person, or similar person during your current pregnancy? ☐ Yes ☐ No

If yes, what agency? ______________________

25. Have you used any of the following during your pregnancy? (Read list and check all that apply)
For each substance used, ask: When did you last use this? How often did you use it?

	Have used	Last used	Frequency
Caffeine	☐ No ☐ Yes	☐ Currently, within the past week ☐ Formerly, last used: ________	☐ Daily ☐ Monthly ☐ Weekly ☐ Less than monthly
Cigarettes / Tobacco	☐ No ☐ Yes	☐ Currently, within the past week ☐ Formerly, last used: ________	☐ Daily ☐ Monthly ☐ Weekly ☐ Less than monthly
Non-Prescription drugs	☐ No ☐ Yes	☐ Currently, within the past week ☐ Formerly, last used: ________	☐ Daily ☐ Monthly ☐ Weekly ☐ Less than monthly
Prescription drugs	☐ No ☐ Yes	☐ Currently, within the past week ☐ Formerly, last used: ________	☐ Daily ☐ Monthly ☐ Weekly ☐ Less than monthly
Alcohol	☐ No ☐ Yes	☐ Currently, within the past week ☐ Formerly, last used: ________	☐ Daily ☐ Monthly ☐ Weekly ☐ Less than monthly
Other drug	☐ No ☐ Yes	☐ Currently, within the past week ☐ Formerly, last used: ________	☐ Daily ☐ Monthly ☐ Weekly ☐ Less than monthly

☐ I certify the information provided in this enrollment application is accurate and truthful to the best of my knowledge.

Your name: ______________________ Date______________

Agency Use Only

Staff Signature: ______________________ Date:______________