



Pregnant Women Family Strengths Form

FCP-619

Family Name: _____

Date: _____

EDUCATION	HOUSING/COMMUNITY
<p>Name of A01: _____ Name of A02: _____ Education Level of (pull from application): A01: _____ A02: _____</p> <p>Do you have plans to pursue any education or career related goals? A01: <input type="checkbox"/> YES <input type="checkbox"/> NO A02: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, what do you have planned and when?</p> <p>Is there anything we can do to help you reach your educational goal?</p> <p>If you had to tell your child(ren) one thing about learning what would you say?</p>	<p>Do you rent, own, lease or have other living arrangements? (This may need to be updated from the application at the time of enrollment.)</p> <p>Are payments for housing affordable for you? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>How many people live in your household?</p> <p>Do you have concerns about your current housing situation? If so, what are they? (safety, healthy living conditions)</p> <p>Do you feel that your community/neighborhood is a safe place to live? Please explain:</p> <p>What do you think would make your community a better place to live?</p>

EMPLOYMENT	TRANSPORTATION
<p>What type of skills, interests, or talents do you have? What do others say you do well? A01: _____ A02: _____</p> <p>Are you currently employed? A01: <input type="checkbox"/> YES <input type="checkbox"/> NO A02: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If yes, where and how long?</p> <p>If no, do you wish to obtain employment, or do you need assistance with job skills? Employment: A01: <input type="checkbox"/> YES <input type="checkbox"/> NO A02: <input type="checkbox"/> YES <input type="checkbox"/> NO Skills: A01: <input type="checkbox"/> YES <input type="checkbox"/> NO A02: <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>What type of work would you like to do and/or types of work have you done in the past? A01: _____ A02: _____</p>	<p>Do you have access to safe transportation for prenatal exam appointments? <input type="checkbox"/> YES <input type="checkbox"/> NO What is your main source of transportation? Please circle response: own vehicle, vehicle of friend/family member, walking, bus or other public transportation.</p> <p>Do you currently have a valid driver's license? A01: <input type="checkbox"/> YES <input type="checkbox"/> NO A02: <input type="checkbox"/> YES <input type="checkbox"/> NO If no, have there been problems with obtaining or keeping a license? Please explain:</p> <p>In the state of Virginia, it is a law that all children under 8 years of age be in a child safety seat while traveling. Do you need information about obtaining or correctly using a car seat for your newborn? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>In the state of Virginia, it is a law that all passengers wear seat belts while traveling. Do you need information about obtaining or using seat belts in your main transportation source? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you need information about possible resources regarding safe driving practices or about insurance for your car? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>

FAMILY FINANCES	PRENATAL KNOWLEDGE
<p>Do you or your family have other financial needs at this time? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Would you like information about: Reducing debt? <input type="checkbox"/> YES <input type="checkbox"/> NO Credit Counseling? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>Is this your first pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No, If no how many? _____</p> <p>What is something you would like to learn about during this pregnancy? _____</p> <p>Are you interested in attending birthing classes? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>



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SERVICES & RESOURCES	FAMILY WELLNESS
<p>If you found yourself in need of a service or information about a service, what might you do? (This is an excellent opportunity for you to introduce the Parent Handbook & Resource Guide and to explain about our Advocacy services)</p> <p>Do you feel you have knowledge of the services that are available for persons in your community? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Do you or have you used agency/program services? If so, what and when? (This can be pulled from the application but updated here)</p>	<p>Do you have access to total care for adult members of your family? (Vision, dental, medical, mental health services, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO If no, what would you need help with?</p> <p>Are you receiving a doctor/medical providers care during this pregnancy? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, who?</p> <p>Will your child(ren) be covered by some type of medical plan such as a medical card or private insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, specify coverage:</p> <p>Are there current concerns about alcohol/drug use for you or anyone in your household? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Are you aware of the effects of alcohol, drug abuse, smoking has on your unborn baby? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>

SPECIAL NEEDS/FAMILY SUPPORT	PRENATAL SERVICES
<p>Do you have a child or family member with a disability or special need? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>How would you describe the need?</p> <p>Is there something we could do to help meet that need? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, explain.</p> <p>Do you have people you can turn to when you need help, advice or just someone to listen? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Who has been helpful to you in raising your child(ren) and/or coping with daily situations?</p> <p>Are there specific emotional health needs that we might be able to help with? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please specify:</p>	<p>Are you currently receiving benefits from the Women, Infant, and Children Nutrition program (WIC)? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If NO, are you interested in signing up for this service? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>What hospital will you deliver your baby at? _____</p> <p>Have you toured the hospital in which you plan to deliver? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Would you prefer a natural birth or help with the pain during childbirth? _____</p> <p>Would you be interested in attending classes at the local health department to be eligible for a free car seat? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Are you planning to breastfeed? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES are you interested in breastfeeding classes? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>

Family Signature: _____

Staff Signature: _____