

COMMUNITY ACTION OF SOUTHEAST IOWA
EARLY HEAD START
PRENATAL RISK ASSESSMENT

Mother's Name: _____ Due Date: _____
Assessment Date: _____

Risks:

Is the pregnancy considered high risk? _____
Have you ever had a high risk pregnancy? _____

Risk factors: (Y or N)

___ Toddlers in the home	NOTES: _____
___ Homelessness	_____
___ Impaired cognitive ability	_____
___ Job-related risk	_____
___ Lack of social supports	_____
___ Language barrier	_____
___ Inadequate/unsafe housing	_____
___ Victim of physical abuse/violence	_____
___ Miscarriage or Neonatal Death	
___ Cigarette , drug or alcohol use	
___ Other: Specify _____	

Supports:

Participation in support or educational groups during pregnancy: (Y or N)

___ Prenatal exercise	NOTES: _____
___ Prenatal general discussion	_____
___ Birth education (Lamaze)	_____
___ Breast feeding preparation	_____
___ Preparing for baby care	_____
___ Personal Development	_____
___ Parenting education	_____
___ Other: Specify _____	

Are you receiving or have you ever received:

___ Substance abuse treatment
___ Mental health counseling/treatment
___ Other: Specify _____

Updates (2nd or 3rd Assessment): (Hospitalizations, bed rest, Gestational Diabetes, Toxemia, etc.?)

