



PARTICIPANT INFORMATION FORM

ADOLESCENT PARENTING PROGRAM – PREGNANT TEEN

Date of Intake: ____ / ____ / _____

Scheduled Date for Initial Goal Planning (45-60 days after intake): ____ / ____ / _____

First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: ____ / ____ / _____

Primary Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Address (if applicable): _____

City: _____ State: _____ Zip Code: _____

Phone #1: ____ - ____ - _____

- Home
- Cell
- Other _____

Phone #2: ____ - ____ - _____

- Home
- Cell
- Other _____

Phone #3: ____ - ____ - _____

- Home
- Cell
- Other _____

Race/Ethnicity (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Native American/American Indian |
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> White |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Other _____ |

With whom do you live? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Alone (or with child) | <input type="checkbox"/> Other Relative of Child's Father |
| <input type="checkbox"/> Mother/Stepmother | <input type="checkbox"/> Friend |
| <input type="checkbox"/> Father/Stepfather | <input type="checkbox"/> Foster Home |
| <input type="checkbox"/> Other Relatives | <input type="checkbox"/> Group Home or Shelter |
| <input type="checkbox"/> Child's Father/Mother | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Parent/Guardian of Child's Father | |



Who referred you to APP? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> School | <input type="checkbox"/> Therapist/Counselor |
| <input type="checkbox"/> Health Department | <input type="checkbox"/> Family Member |
| <input type="checkbox"/> Other Health Provider | <input type="checkbox"/> Current or Past APP Participant |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Friend |
| <input type="checkbox"/> DSS | <input type="checkbox"/> Self |
| <input type="checkbox"/> Juvenile Services | <input type="checkbox"/> Other _____ |

Parent/Legal Guardian Information

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #1: _____ - _____ - _____

- Home
- Cell
- Other _____

Phone #2: _____ - _____ - _____

- Home
- Cell
- Other _____

Phone #3: _____ - _____ - _____

- Home
- Cell
- Other _____

Emergency Contact Information

Enter if different from Parent/Legal Guardian listed above.

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #1: _____ - _____ - _____

- Home
- Cell
- Other _____

Phone #2: _____ - _____ - _____

- Home
- Cell
- Other _____

Phone #3: _____ - _____ - _____

- Home
- Cell
- Other _____

Relation to you:

- | | |
|---|---|
| <input type="checkbox"/> Father | <input type="checkbox"/> Sister |
| <input type="checkbox"/> Mother | <input type="checkbox"/> Grandparent |
| <input type="checkbox"/> Other guardian | <input type="checkbox"/> Other relative |
| <input type="checkbox"/> Brother | <input type="checkbox"/> Non-relative |

Resources

What services do you currently receive? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> TANF/Work First | <input type="checkbox"/> Foster Care |
| <input type="checkbox"/> Food Stamps | <input type="checkbox"/> Child Support |
| <input type="checkbox"/> Unemployment Benefits | <input type="checkbox"/> Child Services Coordination (CSC) |
| <input type="checkbox"/> WIC | <input type="checkbox"/> Maternal Care Coordination (MCC) |
| <input type="checkbox"/> Day Care Subsidy | <input type="checkbox"/> Maternal Outreach Worker (MOW) |
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> Baby Love |
| <input type="checkbox"/> Child Protective Services | <input type="checkbox"/> Resources from Church |
| <input type="checkbox"/> Health Department | <input type="checkbox"/> Public Housing |
| <input type="checkbox"/> Drug Treatment | <input type="checkbox"/> After School Program |
| <input type="checkbox"/> Juvenile Services | <input type="checkbox"/> Support Our Students (SOS) |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Health Choice | <input type="checkbox"/> None |
| <input type="checkbox"/> SSI/SSA | <input type="checkbox"/> Not Sure |

What assistance or services do you need? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Birth Control | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Health Care for Self | <input type="checkbox"/> Housing |
| <input type="checkbox"/> Health Care for Child | <input type="checkbox"/> Financial Assistance |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Mental Health Treatment |
| <input type="checkbox"/> Job Preparation | <input type="checkbox"/> Substance Abuse Treatment |
| <input type="checkbox"/> Academic Support | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Parenting Education | <input type="checkbox"/> Other _____ |

Education

What type of educational program are you enrolled in?

- Not Currently Enrolled (you must enroll within the next 60 days to participate in APP)
- Regular Education (includes charter schools & homebound)
- GED or Alternative Education Program (night school, virtual school, home school)

Name of School or Program: _____

What grade are you currently in?

- | | |
|---|-----------------------------|
| <input type="checkbox"/> Not Currently Enrolled | <input type="checkbox"/> 8 |
| <input type="checkbox"/> Ungraded School | <input type="checkbox"/> 9 |
| <input type="checkbox"/> 4 | <input type="checkbox"/> 10 |
| <input type="checkbox"/> 5 | <input type="checkbox"/> 11 |
| <input type="checkbox"/> 6 | <input type="checkbox"/> 12 |
| <input type="checkbox"/> 7 | |

What level of grades did you achieve on your most recent report card?

- Above Average (mostly A's and B's)
- Average (mostly C's and D's)
- Below Average (F's)

What is your educational goal? (Check all that apply)

- Graduate from High School or earn GED
- Attend Vocational or Trade School
- Attend 2-year College Program
- Attend 4-year College Program
- Attend more than 4 years of college

Parents and Siblings

How old was your mother when she had her first child?

- 14 or younger
- 15-19
- 20 or older
- Not Sure

Did any of your brothers or sisters become parents before graduating from high school?

- Don't have any brothers or sisters
- No
- Yes
- Not Sure

Did any of your brothers or sisters drop out of school before graduating?

- Don't have any brothers or sisters
- No
- Yes
- Not Sure

What was the highest grade completed by your mother?

- | | |
|---|---|
| <input type="checkbox"/> 8 th Grade or lower | <input type="checkbox"/> GED |
| <input type="checkbox"/> 9 th Grade | <input type="checkbox"/> Some College |
| <input type="checkbox"/> 10 th Grade | <input type="checkbox"/> College Degree or higher |
| <input type="checkbox"/> 11 th Grade | <input type="checkbox"/> Not Sure |
| <input type="checkbox"/> 12 th Grade | |

What was the highest grade completed by your father?

- 8th Grade or lower
- 9th Grade

- 10th Grade
- 11th Grade
- 12th Grade
- GED

- Some College
- College Degree or higher
- Not Sure

Employment

Do you currently have a job?

- Yes

How many hours per week do you work?

- 1-10 hours
- 11-20 hours
- 21-30 hours
- 30 or more hours

Do you think you are learning skills at your current job that could help you get a better job?

- Yes
- No
- Not sure

Do you think you will have good chances for promotions at your current job?

- Yes
- No
- Not sure

- No

Have you ever had a job?

- Yes
- No

Are you looking for a job (or a better job) right now?

- Yes
- No

What is/are the reason(s)? (check all that apply)

- Like my current job
- Too young to work
- There are no jobs available that I want
- Cannot find a job
- Not sure where/how to get a job
- Do not have the necessary training, skills, or experience to get a job
- Cannot arrange childcare
- Do not have time to work due to other responsibilities
- Parent/guardian will not allow me to work
- Do not have transportation
- Do not feel well enough to work due to pregnancy
- Not interested in working

Legal Issues

Have you ever been arrested?

- No
- Yes

Have you ever been sentenced to spend time in a correctional institution (jail, prison, youth detention center, etc.)?

- Yes
- No

Have you ever been on probation?

- Yes

Are you currently on probation?

- Yes

Name and Contact Information of Probation Officer:

- No

- No

Have you ever been reported to Child Protective Services for suspected child abuse or neglect?

- Yes
- No

Experience with Abuse/Assault

Have you ever experienced physical abuse (hitting, pushing, choking)?

- Yes

By whom? (check all that apply)

- Current Partner (boyfriend/girlfriend)
- Former Partner
- Parent/Guardian
- Sibling
- Other

- No

Have you ever experienced emotional abuse (name calling, put-downs)?

- Yes

By whom? (check all that apply)

- Current Partner (boyfriend/girlfriend)
- Former Partner
- Parent/Guardian
- Sibling
- Other

- No

Have you ever witnessed a sibling being physically or emotionally abused?

- Yes
- No

Have you ever witnessed a parent being physically or emotionally abused?

- Yes
- No

Have you ever been forced to have sex (vaginal, anal, or oral) against your will?

- Yes
 - By whom? (check all that apply)
 - Current Partner (boyfriend/girlfriend)
 - Former Partner
 - Parent/Guardian
 - Other relative
 - Other
- No

Have you ever experienced any unwanted sexual situation?

- Yes
 - By whom? (check all that apply)
 - Current Partner (boyfriend/girlfriend)
 - Former Partner
 - Parent/Guardian
 - Other relative
 - Other
- No

Pregnancy

Are you currently pregnant?

- Yes (Continue with questions below.)
- No (Please use Intake Form for parenting teens.)

When is your due date? ____/____/____

How many times have you been pregnant (including current pregnancy and any abortions, miscarriages, or still births)?

- 1
- 2
- 3 or more

Would you like to have another child?

- Yes
 - How soon? _____
- No

Which of the following do you currently suffer from? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Pre-eclampsia/Toxemia | <input type="checkbox"/> Pregnancy and Epilepsy |
| <input type="checkbox"/> Pre-term Labor | <input type="checkbox"/> Ectopic Pregnancy |
| <input type="checkbox"/> Gestational Diabetes (diabetes during pregnancy only) | <input type="checkbox"/> Fibroids and Pregnancy |
| <input type="checkbox"/> Multiple Births | <input type="checkbox"/> Infectious Disease and Pregnancy |
| <input type="checkbox"/> Pregnancy and Lupus | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Pregnancy and Sickle Cell Anemia | <input type="checkbox"/> Grinding your teeth |
| | <input type="checkbox"/> Headaches |

- Hard time sleeping
- Unable to concentrate
- Feeling grouchy
- Sleeping too much
- Loss of appetite
- Wanting to hurt myself
- Indigestion or gas pains
- Shaking hands
- Upset stomach
- Pounding heart
- Muscle tension
- Ringing in ears
- Eating too much

- Eating disorder
- Feeling bad about myself
- High blood pressure
- Diabetes
- Take prescription medication
- Depression
- Anxiety
- Asthma
- Recurrent sexually transmitted infections
- Other _____
- None

Have you received any prenatal care yet?

- Yes
 - When did you begin receiving prenatal care?
 - 1st Trimester
 - 2nd Trimester
 - 3rd Trimester
 - How many prenatal visits have you had?
 - 0
 - 1-3
 - 4-6
 - 7 or more
- No

Have you been hospitalized during your pregnancy?

- Yes
- No

Do you currently smoke?

- Yes
- No

Does anyone in your household currently smoke?

- Yes
- No

Do you currently drink alcohol?

- Yes
 - How many drinks per week?
 - 0-1
 - 2-3
 - 4-5
 - More than 5
- No

Have you ever drunk alcohol in the past?

- Yes
- No

Do you currently use illicit or prescription drugs or other substances to get high?

- Yes
 - How often?
 - Less than once per month
 - 1-2 times per month
 - 3-4 times per month
 - More than once per week
- No

Do you currently have a health care provider who you can see on a regular basis?

- Yes. Name of Practice/Provider: _____
- No

Do you have health insurance?

- Yes
 - Medicaid
 - Health Choice
 - Other
- No

Father of Child

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ - _____ - _____

- Home
- Cell
- Other _____

Age (or approximate age):

- 14 or younger
- 15-19
- 20-25
- 26 or older

What is the school enrollment status of your child's father?

- Enrolled in school or equivalent program
- Graduated from school or completed GED
- Enrolled in college or vocational training program
- Graduated from college or vocational training program
- Not currently enrolled
- Not sure

How many hours per week does your child's father work?

- 1-10 hours
- 11-20 hours
- 21-30 hours
- More than 30 hours
- Not currently employed
- Not sure

How many children does your child's father have (including yours)?

- 1
- 2
- 3 or more
- Not sure

About how often do you have contact with your child's father?

- Every day
- Several times a week
- Several times a month
- Less than once a month
- No contact

Do you think your child's father would be interested in attending APP group meetings and activities?

- Yes
- No
- Not sure

Would you like your child's father to attend APP group meetings and activities?

- Yes
- No
- Not sure

Do you think your child's father would be interested in being present for APP home visits?

- Yes
- No
- Not sure

Would you like your child's father to be present for APP home visits?

- Yes
- No
- Not sure