PARTICIPANT INFORMATION FORM

ADOLESCENT PARENTING PROGRAM – PARENTING 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):

- ❑ Asian/Pacific Islander
- ❑ African American/Black
- ❑ Hispanic/Latino
- ❑ Native American/American Indian
- ❑ White
- ❑ Other _____

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

- ❑ Alone (or with child)
- ❑ Mother/Stepmother
- ❑ Father/Stepfather
- ❑ Other Relatives
- ❑ Child's Father/Mother
- ❑ Parent/Guardian of Child's Father
- ❑ Other Relative of Child's Father
- ❑ Friend
- ❑ Foster Home
- ❑ Group Home or Shelter
- ❑ Other _____

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

- ❑ School
- ❑ Health Department
- ❑ Other Health Provider
- ❑ Hospital
- ❑ DSS
- ❑ Juvenile Services
- ❑ Therapist/Counselor
- ❑ Family Member
- ❑ Current or Past APP Participant
- ❑ Friend
- ❑ Self
- ❑ 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:

- ❑ Father
- ❑ Mother
- ❑ Other guardian
- ❑ Brother
- ❑ Sister
- ❑ Grandparent
- ❑ Other relative
- ❑ Non-relative

Resources

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

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

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

- ❑ Birth Control
- ❑ Health Care for Self
- ❑ Health Care for Child
- ❑ Child Care
- ❑ Job Preparation
- ❑ Academic Support
- ❑ Parenting Education
- ❑ Transportation
- ❑ Housing
- ❑ Financial Assistance
- ❑ Mental Health Treatment
- ❑ Substance Abuse Treatment
- ❑ Other _____
- ❑ 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?

- ❑ Not Currently Enrolled
- ❑ Ungraded School
- ❑ 4
- ❑ 5
- ❑ 6
- ❑ 7
- ❑ 8
- ❑ 9
- ❑ 10
- ❑ 11
- ❑ 12

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?

- ❑ 8th Grade or lower
- ❑ 9th Grade
- ❑ 10th Grade
- ❑ 11th Grade
- ❑ 12th Grade
- ❑ GED
- ❑ Some College
- ❑ College Degree or higher
- ❑ Not Sure

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 (Please us the Intake From for pregnant teens.)
- ❑ No (Continue to questions below.)

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

- ❑ 1
- ❑ 2
- ❑ 3 or more

Would you like to have another child?

- ❑ Yes – How soon? _____
- ❑ No

What complications did you have during your most recent pregnancy? (Check all that apply)

- ❑ Pre-eclampsia/Toxemia
- ❑ Pre-term Labor
- ❑ Gestational Diabetes (diabetes during pregnancy only)
- ❑ Multiple Births
- ❑ Pregnancy and Lupus
- ❑ Pregnancy and Sickle Cell Anemia
- ❑ Pregnancy and Epilepsy
- ❑ Ectopic Pregnancy
- ❑ Fibroids and Pregnancy
- ❑ Infectious Disease and Pregnancy
- ❑ Other _____
- ❑ None
- ❑ Not Sure

When did you begin receiving prenatal care during your most recent pregnancy?

- ❑ Did not receive any prenatal care
- ❑ 1st Trimester
- ❑ 2nd Trimester
- ❑ 3rd Trimester

How many prenatal visits did you have?

- ❑ 0
- ❑ 1-3
- ❑ 4-6
- ❑ 7 or more

Do you currently smoke?

- ❑ Yes
- ❑ No

  Did you smoke in the past?

  - ❑ Yes

    Were you able to stop smoking during your pregnancy?

    - ❑ Yes
    - ❑ No
  - ❑ 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

    Were you able to stop drinking during your pregnancy?

    - ❑ Yes
    - ❑ No
  - ❑ 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

Did you go to your post partum check up after you gave birth?

- ❑ Yes

  Did your health care provider say you need another appointment with him/her or another type of health care provider?

  - ❑ Yes
  - ❑ No
- ❑ No

Are you currently using a family planning method to prevent another pregnancy?

- ❑ Yes
  - What method of birth control do you use? (check all that apply)
    - ❑ Abstinence
    - ❑ Birth Control Pills
    - ❑ Condom (Female)
    - ❑ Condom (Male)
    - ❑ Contraceptive Patch
    - ❑ Diaphragm
    - ❑ Hormonal Implant
    - ❑ Hormonal Injection
    - ❑ IUD (ParaGard, Mirena, Skyla)
    - ❑ Spermicides
    - ❑ Sponge
    - ❑ Vaginal Ring
    - ❑ Withdrawal
- ❑ No

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

- ❑ Back pain
- ❑ Grinding your teeth
- ❑ 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

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

- ❑ Yes – Name of Practice/Provider: _____
- ❑ No

Do you have a health care provider for your child who you can see on a regular basis?

- ❑ Yes – Name of Practice/Provider:_____
- ❑ No

Do you have health insurance for yourself?

- ❑ Yes
  - ❑ Medicaid
  - ❑ Health Choice
  - ❑ Other
- ❑ No

Do you have health insurance for your child?

- ❑ Yes
  - ❑ Medicaid
  - ❑ Health Choice
  - ❑ Other
- ❑ No

Child Information

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

Child's Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___

Child's Sex:

- ❑ Male
- ❑ Female

Child's Birth Weight: _____ lbs. _____ oz.

At what stage was your pregnancy when your child was born?

- ❑ Premature (less than 36 weeks)
- ❑ Pre-term (36-37 weeks)
- ❑ Full-term (more than 38 weeks)

What health problems does your child have? (Check all that apply)

- ❑ Low Birth Weight
- ❑ Anemia
- ❑ Heart Problems
- ❑ Lung Problems, including asthma
- ❑ Spina Bifida
- ❑ Cleft Lip or Palate
- ❑ Failure to Thrive
- ❑ Other _____
- ❑ None

Did your baby spend time in the hospital for more than two days?

- ❑ Yes. What was the reason? _____
  Did your baby spend time in the neonatal intensive care unit (NICU)?
  - ❑ Yes
  - ❑ No
- ❑ No

What are your child care arrangements? (Check all that apply)

- ❑ Parent/Guardian
- ❑ Relatives
- ❑ Daycare at School
- ❑ Daycare Not at School (Home or Center Daycare)
- ❑ Friends
- ❑ Other _____

Is your child up to date with immunizations?

- ❑ Yes
- ❑ No
- ❑ Not Sure

Twin (if applicable):

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

Child's Sex:

- ❑ Male
- ❑ Female

Child's Birth Weight: _____ lbs. _____ oz.

What health problems does your child have? (Check all that apply)

- ❑ Low Birth Weight
- ❑ Anemia
- ❑ Heart Problems
- ❑ Lung Problems, including asthma
- ❑ Spina Bifida
- ❑ Cleft Lip or Palate
- ❑ Failure to Thrive
- ❑ Other _____
- ❑ None

Did your baby spend time in the hospital for more than two days?

- ❑ Yes. What was the reason? _____
  Did your baby spend time in the neonatal intensive care unit (NICU)?
  - ❑ Yes
  - ❑ No
- ❑ No

What are your child care arrangements? (Check all that apply)

- ❑ Parent/Guardian
- ❑ Relatives
- ❑ Daycare at School
- ❑ Daycare Not at School (Home or Center Daycare)
- ❑ Friends
- ❑ Other _____

Is your child up to date with immunizations?

- ❑ Yes
- ❑ No
- ❑ Not Sure

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 does your child have contact with his/her 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