

PARTICIPANT INFORMATION FORM

ADOLESCENT PARENTING PROGRAM – PARENTING TEEN

Type:

- New Intake
- Update of Current Participant (done every six months)

Date of Intake: ____ / ____ / _____

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

Program ID: ____

Participant ID: _____

(First and last initial followed by month and day of birthday. For example, “jd0322” for Jackie Doe whose birthday is on March 22nd)

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
- Alternate

Phone #2: ____ - ____ - _____

- Home
- Cell
- Alternate

Phone #3: ____ - ____ - _____

- Home
- Cell
- Alternate

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"/> Parent/Guardian of Child’s Father |
| <input type="checkbox"/> Mother/Stepmother | <input type="checkbox"/> Other Relative of Child’s Father |
| <input type="checkbox"/> Father/Stepfather | <input type="checkbox"/> Friend |
| <input type="checkbox"/> Other Relatives | <input type="checkbox"/> Foster Home |
| <input type="checkbox"/> Child’s Father/Mother | <input type="checkbox"/> Group Home or Shelter |

Other _____

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
- Alternate

Phone #2: _____ - _____ - _____

- Home
- Cell
- Alternate

Phone #3: _____ - _____ - _____

- Home
- Cell
- Alternate

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
- Alternate

Phone #2: _____ - _____ - _____

- Home
- Cell
- Alternate

Phone #3: _____ - _____ - _____

- Home
- Cell
- Alternate

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?

- | | |
|---|---|
| <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 | |

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?

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

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 Form 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)

- | | |
|--|---|
| <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"/> Other _____ |
| <input type="checkbox"/> Pregnancy and Sickle Cell Anemia | <input type="checkbox"/> None |
| | <input type="checkbox"/> 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, Morena)
 - Spermicides
 - Sponge
 - Vaginal Ring
 - Withdrawal
- No

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

- | | |
|---|--|
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Grinding your teeth | <input type="checkbox"/> Eating too much |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Hard time sleeping | <input type="checkbox"/> Feeling bad about myself |
| <input type="checkbox"/> Unable to concentrate | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Feeling grouchy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Take prescription medication |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Wanting to hurt myself | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Indigestion or gas pains | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Shaking hands | <input type="checkbox"/> Recurrent sexually transmitted infections |
| <input type="checkbox"/> Upset stomach | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Pounding heart | <input type="checkbox"/> None |
| <input type="checkbox"/> Muscle tension | |

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

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

Is your child up to date with immunizations?

- Yes
- No
- Not Sure

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 _____

Twin:

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

Father of Child

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

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ - _____ - _____

- Home
- Cell
- Alternate

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?

- Everyday
- Several times a week
- Once a week
- 1 to 3 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