

Crossroads – CTad- Woman

New Family/Family Demographics Screen (Fill-out once for entire family)

Parent/Guardian1

Participant

Last Name: _____ First Name: _____ M.I. _____

Proof of Identification: _____ SSN: _____ DOB: _____

Marital Status: _____ Education Level: _____

Parent/Guardian2

Last Name: _____ First Name: _____ M.I. _____

Proof of Identification: _____ SSN: _____ DOB: _____

Marital Status: _____ Education Level: _____

Caretaker

Last Name: _____ First Name: _____ M.I. _____

Proof of Identification: _____ SSN: _____ DOB: _____

Marital Status: _____ Education Level: _____

Physical Address:

Street: _____

Street 2: _____

ZIP: _____ City: _____ State: _____ County: _____

Proof of Residence: _____

Homeless/Incarcerated Status: _____ Migrant Status: _____

Mailing Address:

Street: _____

Street 2: _____

ZIP: _____ City: _____ State: _____ County: _____

Telephones:

Telephone Number: _____ Type: H, C, W, F, M Primary: _____ Carrier: _____

Telephone Number: _____ Type: H, C, W, F, M Primary: _____ Carrier: _____

Voter Registration:

Communication Options:

Language Read: _____ Language Spoken: _____ Interpreter Sign Language Interpreter

Email Address: _____ Preferred Method of Contact: _____

Family Assessment Screen (Fill-out once for entire family)

- 1. Does anyone smoke inside your house? Yes No
- 2. Mother enrolled in WIC during pregnancy? Yes No
- 3. Has adequate household food storage and preparation? Yes No
- 4. Has household food insecurity? Yes No
- 5. Source of drinking water? City Not Sure Well Cistern Spring Other
- 6. Where did you hear about WIC? _____
- 7. Did you breastfeed in the Hospital? Yes No

Income Screen

Family Size _____ No. of Expected Infants _____ Total Family Size _____

Family – Adjunct Participation

Participant _____	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>
Participant _____	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>
Participant _____	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>
Participant _____	SNAP <input type="checkbox"/>	Medicaid <input type="checkbox"/>	TANF <input type="checkbox"/>

Self-Declared Income _____ Self-Declared Income Range _____

Income Details

Source	Proof	Frequency	Amount	Duration

Zero Income Declaration Reason _____ Comparison Frequency _____

Total Income: _____ *** Remember: Foster Children have their own Income Documentation**
[Participant Demographics Screen\(Fill out one page for each participant\)](#)

Identity Information

Last Name: _____ First Name: _____ M.I. _____
 Proof of ID: _____ SSN: _____ DOB: _____ WIC Category: _____

Male Female Foster Child: Yes No

Foster Care Entry Date: _____ or Date unknown _____ Proof of Foster Care: _____

Identity Information

Last Name: _____ First Name: _____ M.I. _____
 Proof of ID: _____ SSN: _____ DOB: _____ WIC Category: _____

Race/Ethnicity

Declared Observed

Ethnicity: Non-Hispanic Hispanic (Circle one)

Race: (Circle all that apply) American Indian or Alaskan Native Asian
 Black or African American White
 Native Hawaiian or Pacific Islander

Physical Presence: Yes No
 Physical Presence exception reason: _____

Incarcerated Status: Yes No
 Immunization Consent: Yes No

Special Needs: (Circle all that apply) Forms assistance Hearing impaired Mentally Challenged
 Physically Disabled Visually Impaired Speech impaired Wheelchair access
 Reading assistance Other: _____

Education – Highest level completed _____

Marital Status: Single Married Separated Divorced Widowed

Employment Status: Full-time Plans to work Full-time Part-time Plans to work Part-time No plans to work

Health Information Screen

Pre-Pregnancy

Pre-pregnancy Weight _____ lbs. _____ ozs.

Cigarettes Per Day

_____ Three Months Prior to Pregnancy _____ Today

Drinks Per Week

_____ Three Months Prior to Pregnancy

_____ Last Trimester

Pregnancy

_____ Last Menstrual Period

_____ Expected Delivery Date _____ 1st Prenatal Healthcare Visit

_____ Number of Prenatal Healthcare Visits

_____ Date last seen by Physician

Proof of Pregnancy _____

Pregnancy cont.

Number of Fetuses this Pregnancy _____ Gravida _____ Para _____

Medical Home: (e.g. ob/gyn, clinic) _____

Dietary Supplement Taken Before Pregnancy: _____

Pregnancy Induced Health Conditions: _____

Health Conditions: _____

Postpartum

Labor Medications: _____

Health Conditions: _____

Pregnancy Induced Health Conditions: _____

Delivery Date: _____ Weight at Delivery _____ lbs. _____ ozs.

Number of Fetuses this Pregnancy: _____ Gravida _____ Para _____

Medical Home (e.g. ob/gyn, clinic) _____

Participant (infant's name) _____

Outcome: Live Term Birth Fetal Death Miscarriage Neonatal Death
Delivery Type: Vaginal Cesarean Weeks Gestation: _____

Birth Length: _____ Birth Weight: _____

Breastfeeding Information

Data Collection Date: _____ Are you breastfeeding? Yes No Ever Breastfed? Yes No

Breastfeeding Frequency: _____

Age Infant Stopped Breastfeeding: _____

Reason Infant Stopped Breastfeeding: _____

Age Supplement Was Given: _____ No. of Wet Diapers/ 24 hr. Period: _____ No. of Stools / 24 hr. Period: _____

Do you give your baby any formula? Yes No

How much formula do you give your infant in a 24-hour period? _____ ozs.

Complications (breastfeeding): _____

Antro/Lab Screen

Height/Weight

Measurement date: _____ Height: _____ Weight: _____ lb. _____ oz.

Collected by: _____ Gestational Age: _____

Blood Work

Blood work Date: _____ Hgb: _____ or Hct _____ Collected by: _____

Exempt Reason: _____ Deferred Reason: _____

Eco-Social Assessment Screen

Participant:

Recipient of Abuse: Yes No Limited Abilities to Feed-Self: Yes No Maternal Intellectual Disability: Yes No
Day Care Status: Yes No Physical Activity: _____ hrs. per day TV/Video Viewing: _____ hrs. per day
Mother participated in WIC during Pregnancy: Yes No Unknown Mother was WIC eligible but did not participate: Yes No
Mother abused alcohol or drugs during her most recent pregnancy: Yes No Unknown

Dietary & Health Screen

Dietary Assessment

Participant's inappropriate Nutrition Practices

_____ Consuming dietary supplements with potentially harmful consequences.

- _____ Consuming a diet very low in calories and/or essential nutrients; or impaired caloric intake or absorption of essential nutrients following bariatric surgery.
- _____ Compulsively ingesting non-food items (pica).
- _____ Inadequate vitamin/mineral supplementation recognized as essential by national public health policy.
- _____ Pregnant woman ingesting foods that could be contaminated with pathogenic micro-organisms.

Dietary & Health Screen

- | | | | | |
|--|-------|------|-----------|--------------------|
| 1. How is your appetite? | Good | Fair | Poor | |
| 2. Are you taking vitamins? | Yes | No | | |
| 3. If so, what vitamins are you taking? | _____ | | | |
| 4. How many servings of vegetables do you eat per day? | 1-2 | 3-4 | 5 or more | None |
| 5. How many servings of vegetables do you eat per day? | 1-2 | 3-4 | 5 or more | None |
| 6. How many servings of dairy do you eat per day? | 1-2 | 3-4 | 5 or more | I do not eat dairy |
| 7. Are you having any issues with feeding your baby? | Yes | No | | |
| 8. Do you have any questions regarding infant formula? | Yes | No | | |

Assigned Risk Factors

Use National Risk Code Sheet

* _____ * _____ * _____ * _____

Issue EBT Card Screen

Select Cardholder _____

Card Number _____ (Card should be 16 digits long. Double check number.)

Certification Signature

Parent/Guardian will sign a hard copy of the Rights and Responsibilities. This document will be scanned in later.

Family Alerts Screen

Add Family Alert Participant Alert: _____

Start Date: _____ End Date: _____

Care Plan Screens

Maintain Care Plan Goals

Family Goals (circle all that apply)

Dairy Intake	Family Mealtimes	Increase Fruits and Vegetables	Healthy Snacks	Physical Activity
Iron Foods	Weaning	Smoke Exposure	Whole Grains	
Free Form Goals: _____				

Individual Goals

Participant 1: _____ Participant 2: _____

Dairy Intake	Family Mealtimes	Increase Fruits and Vegetables	Healthy Snacks	Physical Activity
Iron Foods	Weaning	Smoke Exposure	Whole Grains	
Free Form Goals: _____				

Family Class: _____ Method: _____

Individual Class: _____ Method: _____

Nutrition Education Refusal

Refusal Type:

Family Individual Date: Reason: _____

Referral Program

Program Name: _____ Family Individual _____

Program Name: _____ Family Individual _____

Program Name: _____ Family Individual _____

Care Plan Summary

Nutrition Assessment

Entered by: _____

Issue Benefits

Prescribe Food:

Default Package Any Exceptions: _____

WIC 53 Category: _____ Subcategory: _____

Quantity: _____