Women CTAD

Demographics

WIC ID:
Initial Cert Date:
Reinstate Cd:
LA/Site:
Last Action:
Termination Cd:
Date:
VOC Xfer:
Action Date:
Suspension Cd:
End Dt:
Part. Name L/F/M:
SSN:
Payee Name L/F/M:
SSN:
Address:
City/State/Zip:
Primary Phone:
Second Phone:
Email Addr:
Residence County:
Proxy Name:
Proxy Name:
Date of Birth:
WIC Condition:
Sex:
EDC:
AD Date:
TANF:
Household Size:
Residence Code:
Migrant:
Food Stamps:
Family Income:
Income/RES Init
Education:
Medicaid:
Income Code:
Referred from:
Marital Status:
Self Declared:
Referred to:
Foster Care:
Hispanic:
Is Race Observed or Declared:
RACE:
White:
Black/African Amer:
Amer Ind/Alaskan:
Asian:
Pacific Islander:
Source of drinking water?
Comments:

Behavior Input

In the three months before you became pregnant:

How many cigarettes did you smoke per day?:

How many alcoholic drinks did you have in an average week?

In the last 3 months of your pregnancy:

How many cigarettes did you smoke per day?:

How many alcoholic drinks did you have in an average week?

At this time:

How many cigarettes do you smoke per day?:

Have you tried to quit smoking?:

How many alcoholic drinks do you have in an average week?

Do you use snuff or smokeless tobacco daily?:

Are you currently in treatment for alcohol dependency?:

Lifestyles Input

HOUSEHOLD SMOKE

Does anyone in your household smoke inside the house?:

TV / PHYSICAL ACTIVITY

How many hours per day did you sit and watch television or videos yesterday? Hours

5 A DAY

VEGETABLES - On a typical day, how many servings of vegetables do you eat? Servings

FRUITS - On a typical day, how many servings of fruits do you eat? Servings

MULTIVITAMIN CONSUMPTION

In the month before you got pregnant with this baby, how many times a week did you take a multivitamin (a pill that contains many diffrent vitamins and minerals)? Times

In the last month of this pregnancy, have you taken any vitamins or minerals? Please include those that are prescribed by a doctor and those that are not. Y/N/U

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Health Surveillance

Hemoglob: ____ Hematocr: ____ Lead: ____ Bld Work Date: ____ Last Bld: ____ By: ____

Ht: ____ (In.) Wt: ____ (LBS/OZS) Current BMI: ____ Hgt/Wgt Date: ____ By: ____

Pre-Preg Wt: ____ Pre-preg BMI: ____ Last: ____

This Preg: Medical Care: ____ Last Medical Date: ____ Medical Comments: ____

Total Weight Gain: ____ Weeks Gestation: ____ Dt Prenatal Care Beg: ____ (mm/yyyy)

# of Infants This Pregnancy: ____ Infant 1 Infant 2 Infant 3

Infant Sex/ Infant Condition: ____ ____ | ____ ____ | ____ ____

Infant Birth Weight and Length: ____ ____ | ____ ____ | ____ ____

During this pregnancy: Did you have any type of HIGH BLOOD PRESSURE? ____

Were you told by a doctor you had GESTATIONAL DIABETES? ____

Prev Preg: # of Prev Preg: ____ # of Live Births: ____ Note: Count multiple births as one pregnancy for all 3 fields

Parity: # of Preg > 20 weeks gest: ____ Last Pregnancy > 20 weeks gest end date: ____ mm/dd/yy

Curr: Comments Risk Codes

Curr: Comments

- [ ] Milk and milk products
- [ ] Meat and meat alternatives
- [ ] Cereal and grain group
- [ ] Fruit group
- [ ] Vegetable group
- [ ] Vitamin C source daily
- [ ] Vitamin A source daily

- [ ] Regular, excessive use of fat, sugar, or salt
- [ ] Use of > or = 2 caffeine-containing beverages per day
- [ ] Food or lactose intolerance
- [ ] Other patterns assessed by CPA to be undesirable
  Specify: ____
- [ ] Entirely deficient in at least one of the food groups
  Specify: ____

Recommended Number

Of Servings/Day				
PA	PT	B	NA	NT
4 3	4-5 3-4	4-5 3-4	3 2-3	4 2-3
6	6	6	6	6
2	2	2	2	2
3	3	3	3	3
2	2	2	1	1
1	1	1	3-4/Wk	

Nutrition Education

Is this a secondary or follow-up high risk contact? (Y/N): ____

Topics: Comments

Given By: ____ Date: ____

Description:

Food Prescription

Current

Interval: ____ Pick-up: ____

Food Prescription: Interval:

____ Month 1

____ Month 2

____ Month 3

Diagnosis ____

WIC53 Expiration Date: ____ By: ____

Referred to: ____ ____ ____

Comments ____