School District of Residence \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial \_\_\_ DOB \_\_\_/\_\_\_/\_\_\_\_\_\_

Physical Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Adults \_\_\_\_\_\_\_\_\_ Number of Children \_\_\_\_\_\_

***(Pregnant mom counts as 1 adult & 1 child)***

Spouse/Partners Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_/\_\_/\_\_\_\_\_

Sibling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_/\_\_/\_\_\_\_\_ Sibling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_/\_\_/\_\_\_\_\_

Sibling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_/\_\_/\_\_\_\_\_ Sibling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_/\_\_/\_\_\_\_\_

Sibling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_/\_\_/\_\_\_\_\_ Sibling \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_/\_\_/\_\_\_\_\_

Estimated Annual Income $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SSI  TANF/OWF  FOSTER CHILD  HOMELESS  EMPLOYMENT

**PREGANCY INFORMATION**

Expected due date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Trimester: 1st 2nd 3rd Number of Weeks Pregnant\_\_\_\_\_\_\_\_

Are you currently receiving pre-natal care? YES NO If Yes, with whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Prenatal visits \_\_\_\_\_\_\_\_\_\_\_\_ Any problems with pre-term labor YES NO

Any abnormal tests results during pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bed rest or Medication for pregnancy: YES NO Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Risk, Medical, Nutritional, or Other Problems that may affect pregnancy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please ask: Are you currently:

□ Smoking (How many per day? \_\_\_\_\_\_) □ Using Drugs □ Using Alcohol (How much per day? \_\_\_\_\_\_) □ Overweight □ Underweight □ Living in a Violent Household

Additional Information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_