

**Michigan Maternal-Infant Health Program
Postnatal Risk Screening – Maternal Component**

M2 FAMILY SOCIAL SUPPORT, PARENTING, AND CHILD CARE

2.1A	Do you currently work outside the home?	
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	↓ 2.2

2.1B	How many hours do you work in a typical week?	
<input type="text"/>	<input type="text"/> Hours	↓

2.2	Are you currently attending school?	
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	

2.3	Are you planning to begin work or school in the near future?	
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	↓ 2.5

2.4A	Who cares or will care for your baby while you are at work/school?	
<input type="text"/>		
<input type="checkbox"/>	Don't Know	

2.4B	Do you have any problems finding or paying for reliable child care?	
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	

2.5	Would you describe the father of this baby as:	
<input type="checkbox"/>	Involved in the baby's life and supportive of the baby	↓
<input type="checkbox"/>	Involved in the baby's life but not supportive	
<input type="checkbox"/>	Aware of the baby but not involved with us	
<input type="checkbox"/>	Unaware that he is the father	
<input type="checkbox"/>	REFUSED	

2.6A	Is there someone in your life who you can count on to help you with your baby?	
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	↓ 2.7

2.6B	Who do you count on for support? (check all that apply)	
<input type="checkbox"/>	Partner and/or the baby's father	↓
<input type="checkbox"/>	Parent(s)	
<input type="checkbox"/>	Other child or children	
<input type="checkbox"/>	Other relative(s)	
<input type="checkbox"/>	Friend(s)/Neighbor(s)	
<input type="checkbox"/>	Clergy and/or people at my place of worship	
<input type="checkbox"/>	Other: _____	

2.7	Who spends the most time with your baby?	
<input type="checkbox"/>	I do	↓
<input type="checkbox"/>	My partner/the baby's father	
<input type="checkbox"/>	My parent(s) or the father's parent(s)	
<input type="checkbox"/>	My other children	
<input type="checkbox"/>	My friend(s)/neighbor(s)	
<input type="checkbox"/>	Daycare staff	

2.8	In the past week, how many times have any of your children been spanked because of misbehaving or acting up?	
<input type="text"/>	Times	↓

2.9A	As a child, were you ever involved with Children's Protective Services?	
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	↓ 2.10A

2.9B	How long were you in the custody of Children's Protective Services?	
<input type="text"/>	<input type="text"/>	↓

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2.10A Have you ever been involved with Children’s Protective Services with any of your own children?	
<input type="checkbox"/>	No ↓ 3.1
<input type="checkbox"/>	Yes ➔ 2.10B

2.10B What was the result?	
<input type="checkbox"/>	Out of home placement
<input type="checkbox"/>	Court-mandated counseling
<input type="checkbox"/>	Intensive at-home services ↓
<input type="checkbox"/>	Nothing but talking with them
<input type="checkbox"/>	Other:

M3	SMOKING
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3.1 Which of the following statements would you say best describes your cigarette smoking? Would you say:	
<input type="checkbox"/>	I smoke regularly now – about the same amount as before I was pregnant ➔ 3.2
<input type="checkbox"/>	I smoke regularly now, but I’ve cut down during my pregnancy or since my baby was born ➔ 3.2
<input type="checkbox"/>	I smoke every once in a while ➔ 3.2
<input type="checkbox"/>	I smoked during my pregnancy, but quit smoking once the baby was born ⇒ 3.3
<input type="checkbox"/>	I quit smoking during my pregnancy but have started smoking again since my baby was born. ➔ 3.2
<input type="checkbox"/>	I wasn’t smoking around the time I found out I was pregnant, and I don’t currently smoke cigarettes. ⇒ 3.3
<input type="checkbox"/>	REFUSED ⇒ 3.3

3.2 Do you smoke around the baby (in the same room, same house, same car?)	
<input type="checkbox"/>	Yes ↓
<input type="checkbox"/>	No

3.3 Is there a smoker in the home or someone that regularly visits that smokes?	
<input type="checkbox"/>	Yes ↓
<input type="checkbox"/>	No

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M4 ALCOHOL

4.1 Which of the following statements would you say best describes your alcohol consumption, INCLUDING beer and wine coolers? Would you say:

<input type="checkbox"/>	I drink alcohol regularly now – about the same amount as before I was pregnant	
<input type="checkbox"/>	I drink alcohol regularly now, but I've cut down since the pregnancy	➔ 4.2
<input type="checkbox"/>	I drink alcohol every once in a while	
<input type="checkbox"/>	I drank alcohol some during my pregnancy, but quit drinking once the baby was born	⇒ 4.3
<input type="checkbox"/>	I quit drinking alcohol during my pregnancy but have started drinking again since my baby was born.	➔ 4.2
<input type="checkbox"/>	I quit drinking alcohol during my pregnancy and have not started drinking again.	⇒ 4.3
<input type="checkbox"/>	I wasn't drinking alcohol around the time I found out I was pregnant, and I don't currently drink.	⇒ 4.3
<input type="checkbox"/>	REFUSED	⇒ 4.3

4.2 When you drink, is the baby at home with you?

<input type="checkbox"/>	Yes	
<input type="checkbox"/>	No	↓

4.3 Do others drink or get drunk around your baby?

<input type="checkbox"/>	Yes	
<input type="checkbox"/>	No	↓

M5 DRUG USE

5.1 Does your partner or anyone in your household use street drugs?

<input type="checkbox"/>	Yes	
<input type="checkbox"/>	No	↓
<input type="checkbox"/>	REFUSED	

5.2A During your pregnancy, did you – even just once - use any street drugs, diet pills, or drugs not prescribed by a physician?

<input type="checkbox"/>	Yes	↓ 5.2B
<input type="checkbox"/>	No	⇒ 5.3A
<input type="checkbox"/>	REFUSED	

5.2B What did you use? (check all that apply)
[OPEN ENDED, PROMPT FOR OTHERS]

<input type="checkbox"/>	Marijuana	
<input type="checkbox"/>	PCP	
<input type="checkbox"/>	Crack	
<input type="checkbox"/>	Cocaine	
<input type="checkbox"/>	Heroin	
<input type="checkbox"/>	Uppers/Crank/Meth/Speed	➔ 5.3A
<input type="checkbox"/>	Downers	
<input type="checkbox"/>	LSD	
<input type="checkbox"/>	Diet Pills	
<input type="checkbox"/>	Prescription drugs not prescribed for you	
<input type="checkbox"/>	Other:	

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5.3A	Since your baby was born, have you used any street drugs, diet pills, or drugs not prescribed by a physician?	
<input type="checkbox"/>	Yes	↓ 5.3B
<input type="checkbox"/>	No	⇒ 6.1
<input type="checkbox"/>	REFUSED	

5.3B	What drugs have you used since your baby was born? (check all that apply) [OPEN ENDED, PROMPT FOR OTHERS]	
<input type="checkbox"/>	Marijuana	↓ 6.1
<input type="checkbox"/>	PCP	
<input type="checkbox"/>	Crack	
<input type="checkbox"/>	Cocaine	
<input type="checkbox"/>	Heroin	
<input type="checkbox"/>	Uppers/Crank/Meth/Speed	
<input type="checkbox"/>	Downers	
<input type="checkbox"/>	LSD	
<input type="checkbox"/>	Diet Pills	
<input type="checkbox"/>	Prescription drugs not prescribed for you	
<input type="checkbox"/>	Other:	
<input type="checkbox"/>	None	

M6	STRESS
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6.1	In the last month, how often have you felt nervous and stressed?	
<input type="checkbox"/>	Never	⇒ 7.1
<input type="checkbox"/>	Almost Never	↓
<input type="checkbox"/>	Sometimes	
<input type="checkbox"/>	Fairly Often	
<input type="checkbox"/>	Very Often	
<input type="checkbox"/>	REFUSED	
<input type="checkbox"/>	SNAG	

6.2	With a new baby, pressures and hassles of everyday life can become even harder to cope with. In the last month, have you felt like you were struggling to cope with:	
		YES NO
	Problems with money?	<input type="checkbox"/> <input type="checkbox"/>
	Problems with a personal relationship?	<input type="checkbox"/> <input type="checkbox"/> →
	Demands of family or children?	<input type="checkbox"/> <input type="checkbox"/>
	Demands of work or school?	<input type="checkbox"/> <input type="checkbox"/>

6.3A	In the last month, how often have you felt that you were unable to control the important things in your life?	
<input type="checkbox"/>	Never	↓
<input type="checkbox"/>	Almost never	
<input type="checkbox"/>	Sometimes	
<input type="checkbox"/>	Fairly often	
<input type="checkbox"/>	Very often	

6.3B	In the last month, how often have you felt confident about your ability to handle your personal problems?	
<input type="checkbox"/>	Never	↓
<input type="checkbox"/>	Almost never	
<input type="checkbox"/>	Sometimes	
<input type="checkbox"/>	Fairly often	
<input type="checkbox"/>	Very often	

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6.3C	In the last month, how often have you felt that things were going your way?	
<input type="checkbox"/>	Never	➔
<input type="checkbox"/>	Almost never	
<input type="checkbox"/>	Sometimes	
<input type="checkbox"/>	Fairly often	
<input type="checkbox"/>	Very often	

6.3D	In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	
<input type="checkbox"/>	Never	↓ 7.1
<input type="checkbox"/>	Almost never	
<input type="checkbox"/>	Sometimes	
<input type="checkbox"/>	Fairly often	
<input type="checkbox"/>	Very often	

M7	DEPRESSION AND MENTAL HEALTH
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7.1	Over the past 2 weeks, how often have you felt down, depressed, or hopeless?	
<input type="checkbox"/>	Not at all	↓
<input type="checkbox"/>	★ Several days	
<input type="checkbox"/>	★ More than half the days	
<input type="checkbox"/>	★ Nearly every day	
<input type="checkbox"/>	REFUSED	

7.2	Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?	
<input type="checkbox"/>	Not at all	↓
<input type="checkbox"/>	★ Several days	
<input type="checkbox"/>	★ More than half the days	
<input type="checkbox"/>	★ Nearly every day	
<input type="checkbox"/>	REFUSED	

7.3	Over the past 2 weeks, how often have you had 'nerves' or felt angry, blue, or out of sorts?	
<input type="checkbox"/>	Not at all	➔ 7.4
<input type="checkbox"/>	★ Several days	
<input type="checkbox"/>	★ More than half the days	
<input type="checkbox"/>	★ Nearly every day	
<input type="checkbox"/>	REFUSED	

7.4A	Have you ever had the "baby blues"?	
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	
<input type="checkbox"/>	REFUSED	

7.4B	Have you ever been treated for or told that you have depression, bipolar disorder, or schizophrenia?	
<input type="checkbox"/>	No	↓ ↗ BELOW
<input type="checkbox"/>	Yes	↓ 7.4B.1

7.4B.1	When did you last see a health care provider about this problem?	
MONTH:	<input type="text"/>	YEAR: <input type="text"/> ↓

7.4B.2	Do you have another visit scheduled?	
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	

7.4B.3	Have you been in the hospital or ER for this condition in the last six months?	
<input type="checkbox"/>	Yes	↓ ↗ BELOW
<input type="checkbox"/>	No	

IF ONE OR MORE ANSWERS TO 7.1 – 7.3 ARE MARKED ★, CONTINUE TO 7.5.

OTHERWISE, SKIP TO 8.1

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QUESTIONS 7.4 – 7.13: DEPRESSION FOLLOW UP SCREENING

I'd like to ask you some follow up questions about how you're feeling. I'm going to read you some statements and responses. For each statement, please let me know which response is closest to how you've been in the past 7 days.

7.5	I have been able to laugh and see the funny side of things
<input type="checkbox"/>	As much as I always could
<input type="checkbox"/>	Not quite so much now
<input type="checkbox"/>	Definitely not so much now
<input type="checkbox"/>	Not at all
7.6	I have looked forward with enjoyment to things
<input type="checkbox"/>	As much as I ever did
<input type="checkbox"/>	Rather less than I used to
<input type="checkbox"/>	Definitely less than I used to
<input type="checkbox"/>	Hardly at all
7.7	I have blamed myself unnecessarily when things went wrong
<input type="checkbox"/>	Yes, most of the time
<input type="checkbox"/>	Yes, some of the time
<input type="checkbox"/>	Not very often
<input type="checkbox"/>	No, never
7.8	I have been anxious or worried for no good reason
<input type="checkbox"/>	No, not at all
<input type="checkbox"/>	Hardly ever
<input type="checkbox"/>	Yes, sometimes
<input type="checkbox"/>	Yes, very often
7.9	I have felt scared or panicky for no very good reason
<input type="checkbox"/>	Yes, quite a lot
<input type="checkbox"/>	Yes, sometimes
<input type="checkbox"/>	No, not much
<input type="checkbox"/>	No, not at all

7.10	Things have been getting the best off me
<input type="checkbox"/>	Yes, most of the time I haven't been able to cope at all
<input type="checkbox"/>	Yes, sometimes I haven't been coping as well as usual
<input type="checkbox"/>	No, most of the time I have coped quite well
<input type="checkbox"/>	No, I have been coping as well as ever
7.11	I have been so unhappy that I have had difficulty sleeping
<input type="checkbox"/>	Yes, most of the time
<input type="checkbox"/>	Yes, sometimes
<input type="checkbox"/>	Not very often
<input type="checkbox"/>	No, not at all
7.12	I have felt sad or miserable
<input type="checkbox"/>	Yes, most of the time
<input type="checkbox"/>	Yes, quite often
<input type="checkbox"/>	Not very often
<input type="checkbox"/>	No, not at all
7.13	I have been so unhappy that I have been crying
<input type="checkbox"/>	Yes, most of the time
<input type="checkbox"/>	Yes, quite often
<input type="checkbox"/>	Only occasionally
<input type="checkbox"/>	No, never
7.14	The thought of harming myself has occurred to me
<input type="checkbox"/>	Yes, quite often
<input type="checkbox"/>	Sometimes
<input type="checkbox"/>	Hardly ever
<input type="checkbox"/>	Never

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M8 ABUSE/VIOLENCE

8.1	Do you feel safe in your present relationship?	
	I am not in a relationship right now	↓
	Yes	
	No	
8.2A	Within the last year, have you been hit, kicked, slapped, or otherwise physically hurt by someone?	
	Yes	↓
	No	⇒ 8.4
8.2B	By whom? (Check all that apply)	
	Current partner	↓
	Ex-partner	
	Stranger	
	Others	
	Specify: _____	
8.2C	How many times has this happened?	
	_____ times	↓
8.3A	Since your baby was born, have you been hit, slapped, kicked or otherwise physically hurt by someone?	
	Yes	↓
	No	⇒ 8.4
8.3B	By whom? (Check all that apply)	
	Current partner	↓
	Ex-partner	
	Stranger	
	Others	
	Specify: _____	
8.3C	How many times has this happened?	
	_____ times	↓
8.3D	What part or parts of your body were hurt?	
	Limbs	⇒ 8.3E
	Torso	
	Head	

8.3E	How did this person hurt you? (Score the most severe incident to the following scale):	
	Threats of abuse, including use of a weapon	↓
	Slapping, pushing; no injuries and/or lasting pain	
	Punching, kicking, bruises, cuts and/or continuing pain	
	Beaten up, severe contusions, burns, broken bones	
	Head, internal, and/or permanent injury	
	Use of weapon, wound from weapon	
8.4	Has your partner or someone else now in your life:	
	Called you names, humiliated you, or made you feel that you don't count?	↓
	Kept you from seeing or talking to your family, friends, or other people?	
	Thrown away or destroyed your belongings, threatened pets, or done other things to bully or scare you?	
	Controlled your use of money, your access to money or your ability to work?	
8.5A	Within the past year, has anyone forced you to have sexual activities?	
	Yes	↓
	No	⇒ 8.6
8.5B	Who was it?	
	Current partner	↓
	Ex-partner	
	Stranger	
	Others	
	Specify: _____	
8.5C	How many times has this happened?	
	_____ times	↓

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8.6	Have you ever been emotionally or physically abused by your partner or someone important to you?
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

8.7	Are you afraid of your partner or anyone you listed above?
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

M9 FOOD, NUTRITION, AND HOUSING

9.1A	In the last 12 months, did you (or other adults in your household) ever cut the size of your meals or skip meals because there wasn't enough money for food?
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

9.1B	How often did this happen?
<input type="checkbox"/>	Almost every month
<input type="checkbox"/>	Some months but not every month
<input type="checkbox"/>	In only 1 or 2 months

9.2	Do you receive food stamps?
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

9.3	Would you be interested in having a nutritional aide visit your home and teach you how to stretch your food money and prepare meals?
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

9.4A	Have you ever breastfed your baby?
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

9.4B	Are you breastfeeding now?
<input type="checkbox"/>	No
<input type="checkbox"/>	Yes
	If yes, how many times every 24 hours?
	<input type="text"/>

9.4C	If you are returning to work/school, do you have a plan to help you continue to breastfeed?
<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

9.5	How do you primarily feed your baby?
<input type="checkbox"/>	Breastfeeding
<input type="checkbox"/>	Formula
<input type="checkbox"/>	Solid Foods
<input type="checkbox"/>	Other:
	<input type="text"/>

9.6A	Has your baby ever received formula?
<input type="checkbox"/>	No
<input type="checkbox"/>	Yes

9.6B	If yes:
	At what age did your baby start taking formula?
	<input type="text"/>
	What is the name of your baby's formula?
	<input type="text"/>
	How often does your baby eat?
	<input type="text"/>
	How many ounces?
	<input type="text"/>

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9.7A	Do you hold your baby while you feed him/her a bottle?	
<input type="checkbox"/>	Yes	↓
<input type="checkbox"/>	No	
<input type="checkbox"/>	I never use a bottle to feed my baby	
9.7B	Does your baby receive anything else in the bottle besides formula or breast milk?	
<input type="checkbox"/>	No	↓ 9.8
<input type="checkbox"/>	Yes	↓
9.7C	What?	
<input type="checkbox"/>	Cereal	
<input type="checkbox"/>	Soda	
<input type="checkbox"/>	Sugar water	
<input type="checkbox"/>	Kool-aid/fruit drinks	
<input type="checkbox"/>	Juice	
<input type="checkbox"/>	Herbal Teas	
<input type="checkbox"/>	Other:	
<input type="checkbox"/>		

9.8	At what age do you plan to introduce solid foods to your baby?	
<input type="text"/>	Months	↓

9.9	How many times have you moved in the past 12 months?		
<input type="checkbox"/>	0	↓	
<input type="checkbox"/>	1		
<input type="checkbox"/>	2		
<input type="checkbox"/>	3		
<input type="checkbox"/>	4 or more		
9.10A	Do you currently have any concerns or worries about your housing situation?		
<input type="checkbox"/>	Yes	↓	
<input type="checkbox"/>	No	⇒ 9.11	
9.10B	What are your concerns or worries about housing? (check all that apply) [OPEN ENDED]		
Instability			
<input type="checkbox"/>	No place to live, no regular night time residence, or live in a shelter.	⇒ 9.11	
<input type="checkbox"/>	Eviction or being forced to move out.		
<input type="checkbox"/>	Affordability of current house or apartment		
<input type="checkbox"/>	Strained relations with others in household		
Adequacy			
<input type="checkbox"/>	House or apartment is too crowded.		
<input type="checkbox"/>	Lack of continuous functioning basic utility service (e.g., heat, electricity)		
Safety			
<input type="checkbox"/>	Safety of house/apartment		
<input type="checkbox"/>	Safety of neighborhood		
9.11	How often do you have access to a telephone to make and receive calls where you live?		
<input type="checkbox"/>	Always		
<input type="checkbox"/>	Sometimes		
<input type="checkbox"/>	Never		

END