Early Head Start

Family Relations Screening

Child's Name:____Age:_______
Mother's Name:_ ____Age:_______
Father's Name____ Age:_______
Family Visitor:____
Was this child a premature birth?________________How early?________________
Were you under severe stress during pregnancy? ___yes ____no
If yes, please describe:____

Please check yes or no for the following:

Is your child hypersensitive or hypo sensitive in any of the following areas:

	YES	NO
Hearing	______	_____
Visual	______	_____
Tactile	______	_____
Oral	______	_____

If yes, please describe:____
____
____

Has eye contact with parent	______	_____
Shutters/stiffens when cuddled	______	_____
Resists being picked up	______	_____
Spits up while feeding	______	_____
Has difficulty swallowing	______	_____
Cries continuously	______	_____
Enjoys playing with parent	______	_____
Often goes off by self	______	_____

Do you have any concerns or questions regarding your child's behavior?
Describe:____
____

Has there been any recent separations/changes of caregivers in your child's life?
Describe: When? How long?
____
____

Have there been any major changes or crisis that have affected your family's life over the last year?
Describe:____
____

Do you have any concerns with other children in your home? Please explain:
____

Please describe your child in 3 words:
______________________ __________________________ ______________________

(over)

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Family Relations Screening
(continued)

Are you married? ______ yes ______no If yes, how long? ___________

Are you divorced? ______yes ______no
If yes,
Date of divorce ______________________________________
Does child have contact with father? ______yes ______no
If yes, How often?____
____
If no, why not?____
____
____
Are you living with a significant other? _____yes ______no
Is this person the father of the child? _____yes ______no

Relationship Satisfaction Scale (Optional)
(Please mark your rating of your current relationship:
1=not at all where I would like us to be…. ………………10= beyond my expectations)

-0-------1---------2---------3---------4---------5---------6---------7---------8---------9---------10

Would you like information on relationships? ______yes ______no

Would you like to talk with a counselor? ______yes ______no

____
Parent Signature Date

(Rev. 7/03)

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Early Head Start

Family Relations

Follow-up Form

Mother's Name:____

Father's Name:____

Child's Name:____

Date Screening Completed:_________________

Date Screening Reviewed:__________________

____

(Family Development Coordinator Signature)

Comments:

____

____

____

____

____

Recommendations for follow-up:

____

____

____

____

____

Where:____

Date Discussed with Parents:______________________________________

Parent decision: ____agree ____disagree

____

Parent Signature Date

____

Parent Signature Date

Referrals

Made:____

____

____

____

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Early Head Start

Prenatal Family Relations Screening

Parents to be:
Mother:____Age:_______
Father:____Age:_______

Relationship between parents:____
Anticipated date of arrival:_______________I know my baby's gender:___yes__no
Family Visitor:____

This baby has been anticipated for how long?______________________________
This is my_______child.   Have you lost any children?___yes __no
If yes please explain:____
____

I have night dreams about this baby:___yes___no. If yes, please elaborate:________
____

When I day dream about this baby, I imagine_______________________________
____

Have there been any life changes affecting you or family members within the last year? ___yes ___no If yes, please explain___________________________________
____

Some fears I have for this baby are_______________________________________
I think there is enough money for the things I really need to care for this child ___yes ___no
Emotionally, I feel as prepared to cope with this coming baby as I can be ___yes ___no
Are there any safety concerns for you or your baby?__________________________

My mother, father, grandparents or others who knew me as a baby tell me…….
____
____

The people I have in my personal support system are_________________________
____

When I imagine this baby being born I see___________________________________
____

Things I am doing to let this baby know about life outside______________________
____

I want to talk to a counselor further about some issues that are coming up for me: ___yes ___no
I may want to talk to a counselor after this baby is born if concerns come up: ___yes ___no

(over)

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Prenatal Family Relations Screening
(continued)

Are you married? ____yes ____no If yes, how long? ________________

Are you divorced? ____yes ____no
If yes:
Date of divorce____________________________
Do you plan on being involved in your child's life? ____yes ____no
If yes, how often?____
____
If no, why not?____
____
Are you living with a significant other that is going to have a child?
____yes ____no
Are you the father of the child? ____yes ____no

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