

# PREGNANT WOMAN WIC WORKSHEET

Contact Date: _____	<input type="checkbox"/> New Client/New Group
Date Service Provided: _____	<input type="checkbox"/> New Client/Existing Group
	<input type="checkbox"/> Existing Client
Wizard: <input type="checkbox"/> Prescreen <input type="checkbox"/> PE <input type="checkbox"/> NC <input type="checkbox"/> CC <input type="checkbox"/> RC <input type="checkbox"/> Other _____	

## Demographics

Client Last: _____	First: _____	MI: _____	DOB: _____
Caregiver Last: _____	Caregiver First: _____	MI: _____	
Alternate Last: _____	Alternate First: _____	MI: _____	
PHONE: _____	Msg. Phone: _____	Phone Notes: _____	
Address: _____	City: _____	Zip: _____	
<input type="checkbox"/> Homeless	<input type="checkbox"/> Migrant	Language for Interpreter: _____	

## Race/Ethnicity

Do you consider yourself Hispanic or Latino?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How do you describe your race? Choose all that apply.		
<input type="checkbox"/> American Indian or Alaska Native	Tribe _____	
<input type="checkbox"/> Asian		
<input type="checkbox"/> Black or African American		
<input type="checkbox"/> Native Hawaiian or other Pacific Islander		
<input type="checkbox"/> White		

## Income

Number in Household: _____	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TANF	<input type="checkbox"/> Basic Food Program	<input type="checkbox"/> FDPIR
Source: _____	Proof _____	Income Amount: _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly
			<input type="checkbox"/> Yearly	
Proof ID: _____	Proof Residency: _____	Proof Pregnancy: _____		

## Custom Tab

Due Date _____	Medical Provider _____
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**Measures**

Date: \_\_\_\_\_ Height: \_\_\_\_\_ - \_\_\_\_\_ /8 Weight: \_\_\_\_\_ lb. \_\_\_\_\_ oz. Pre-pregnancy Wt.: \_\_\_\_\_

Date Taken: \_\_\_\_\_ Hgb/Hct: \_\_\_\_\_ Notes \_\_\_\_\_

**Assessment**

Risk Factors: \_\_\_\_\_ Risk Factor Notes: \_\_\_\_\_  
 Or attach Assessment Questions \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 PDHR High Risk Eligibility Begins: \_\_\_\_\_

**Nutrition Education**

Topics	Handouts

**Referrals**

**Streamlined Basic Contact**

WIC Signature Form   
  Check Education (if provided checks)   
  Rights & Responsibilities  
 ID Check   
  Appointment folder   
  Pregnancy Verification  
 Discussed breastfeeding

Voter Registration: \_\_\_\_\_

**Food Package:**

<input type="checkbox"/> Pregnant	<input type="checkbox"/> Fully Breastfeeding	<input type="checkbox"/> Partially Breastfeeding
<input type="checkbox"/> Pregnant with Multiples	<input type="checkbox"/> Fully BF with Multiples	<input type="checkbox"/> Partially BF with Multiples
<input type="checkbox"/> Fully BF Bonus		

**Notes:**

Staff: \_\_\_\_\_ Co-sign: \_\_\_\_\_  
 Once information is entered into the computer, please shred this document to protect client information.



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