Patient Name_____ DOB_____ Today's Date_____

Perinatal Behavioral Health Screening Questions

Women and children's health can be affected by emotional problems, alcohol, tobacco, other drug use and violence. Women and children's health are also affected when these same problems are present in people who are close to them. Our goal is to provide you and your baby with the best care available. Please answer the questions below as accurately as possible.

*Alcohol includes beer, wine, hard cider/hard seltzers, hard liquor and spirits
*Tobacco includes cigarettes, cigars, chewing tobacco, vaping and e-cigarettes
*Drugs include opioids, benzodiazepines, barbiturates, valium, prescription pills, street drugs like heroin, methamphetamine, cocaine, marijuana, kratom, etc.

5 Ps	**Yes**	**No**
1. Did/do any of your **parents** or guardians have a problem with alcohol or other drug use?	☐	☐
2. Did/do any of your friends/**peers** have a problem with alcohol or other drug use?	☐	☐
3. Did/does your **partner(s)** have a problem with alcohol or other drug use?	☐	☐
4. In the **past**, have you had difficulties in your life due to alcohol or other drugs, including prescription medicine?	☐	☐
5. In the **past month**, have you ingested any alcohol, taken any prescriptions or used drugs like marijuana or kratom?	☐	☐
6. Have you smoked any cigarettes, used any tobacco, or vaped in the past 3 months?	☐	☐
7. Over the last few weeks, has worry, anxiety, depression or sadness made it difficult for you to do your work, get along with others or take care of things at home?	☐	☐
8. Are you currently, or have you ever been, in a relationship where you are physically hurt, choked, threatened, controlled or made to feel afraid?	☐	☐
TOTAL YES		

		Yes / No
	In the last 12 months, did you ever **eat less than you felt you should** because there wasn't enough money for food?	☐ ☐
	In the last 12 months, has your **utility company shut off your service** for not paying your bills?	☐ ☐
	Are you worried that in the next 2 months, you **may not have stable housing?**	☐ ☐
	Do problems getting **child care make it difficult for you to work** or study? *(leave blank if you do not have children)*	☐ ☐
	In the last 12 months, have you needed to see a doctor, **but could not because of cost?**	☐ ☐
	In the last 12 months, have you ever had to go without health care because you didn't have **a way to get there?**	☐ ☐
	Do you ever need help **reading hospital materials?**	☐ ☐
	Are you **afraid you might be hurt** in your apartment building or house?	☐ ☐
	If you checked YES to any boxes above, **would you like to receive assistance** with any of these needs?	☐ ☐
	**Are any of your needs urgent?** For example: I don't have food tonight, I don't have a place to sleep tonight	☐ ☐

Are you currently working with a Case Manager? **Yes** ☐ **No** ☐

Case Manager Name: _____Agency Name: _____

Place Patient Label Here