

Patient/Client Name: \_\_\_\_\_  
 Screener Name: \_\_\_\_\_  
 Reviewed by Qualified Provider: \_\_\_\_\_

Date: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Date: \_\_\_\_\_

# Behavioral Health Risks Screening Tool

## for Pregnant Women and Women of Childbearing Age

### Provider Tool

*Women and their children's health can be affected by emotional problems, alcohol, tobacco, other drug use and violence. Women and their children's health are also affected when these same problems are present in people who are close to them. Alcohol includes beer, wine, wine coolers, liquor and spirits. Tobacco products include cigarettes, cigars, snuff and chewing tobacco.*

1. Have you smoked any cigarettes or used any tobacco products in the past three months?	<b>TOBACCO</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
2. Did any of your parents have a problem with alcohol or other drug use?	<b>PARENTS</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
3. Do any of your friends have a problem with alcohol or other drug use?	<b>PEERS</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
4. Does your partner have a problem with alcohol or other drug use?	<b>PARTNER</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
5. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?	<b>PAST</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
6. Check <b>YES</b> if she agrees with any of these statements. In the past month, have you drunk any alcohol or used other drugs? - How many days per month do you drink? _____ - How many drinks on any given day? _____ - How often did you have <b>4 or more drinks per day</b> in the last month? _____	<b>PRESENT</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
7. Check <b>YES</b> if she agrees with any of these statements. In the past 7 days, have you: - Blamed yourself unnecessarily when things went wrong? - Been anxious or worried for no good reason? - Felt scared or panicky for no good reason?	<b>EMOTIONAL HEALTH</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>
8. Are you currently or have you ever been in a relationship where you were physically hurt, choked, threatened, controlled, or made to feel afraid?	<b>VIOLENCE</b>	<b>YES</b> <input type="checkbox"/>	<b>NO</b> <input type="checkbox"/>

### PROVIDER USE ONLY

Review risk.

Review substance use, set healthy goals.

Review and/or administer full AAS or Relationship Assessment Tool / WEB screening. See instructions.

Review and/or administer PHQ-9 if not pregnant / Edinburgh PDS-10 if pregnant. See instructions.

Develop a follow up plan with patient.

Moderate drinking for non-pregnant women is one drink per day. Women who are pregnant or planning to become pregnant should not use alcohol, tobacco, illicit drugs or prescription medication other than as prescribed.

Brief Intervention/Brief Treatment	Y	N	NA
Did you <b>State</b> your medical concern?			
Did you <b>Advise</b> to abstain or reduce use?			
Did you <b>Check</b> patient's reaction?			
Did you <b>Refer</b> for further assessment?			
Did you <b>Provide</b> written information?			