SKIP To A Great Start
Family Risk Assessment

SKIP Family ID: ____________________ Date: ____________________
Family Name: ____________________ District: ____________________

Fill in only 1 circle for each question.	Yes	No
1. Do you have a spouse/partner who helps you take care of your children?	O	O
2. Do you receive Department of Human Service (DHS) support?	O	O
3. Do you receive Women/Infants/Children (WIC)?	O	O
4. Do you receive Child Care Assistance from DHS?	O	O
5. Do receive Social Security Benefits?	O	O
6. Do you have Children's Special Health Care Services (CSHCS)?	O	O
7. Was this a planned pregnancy?	O	O
8. Overall are you happy to be a parent?	O	O
9. Do you need additional help with parenting?	O	O
10. Did you receive inadequate (late/missed visits) or no prenatal care?	O	O
11. Was your child premature (pregnancy lasted fewer than 37 weeks)?	O	O
12. Was your child low-birth weight (5 1/2 lbs. or less at birth)?	O	O
13. Do you have a child with a disability?	O	O
14. Do you have two or more children under the age of 5?	O	O
15. Do either you or your partner have substance abuse issues?	O	O
16. Do either you or your partner have depression and/or other mental health issues?	O	O
17. Were either you or your partner abused and/or neglected as a child?	O	O
18. Do you live in or frequently visit a house that was built before 1978?	O	O
19. Do your children live with or frequently visit an adult whose job or hobby involves exposure to lead?	O	O
20. Does anyone in your household have any long-term illnesses or diseases?	O	O

If anyone in your household has any long-term illnesses or diseases, then please explain: