

# New Parent Support Program (NPSP) Family Information Form

SPONSOR INFORMATION				NPSP CASE ID: 20__ - 0__	
FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER (SSN)			
DATE OF BIRTH	ETHNICITY	EXPECTED DUE DATE			
GRADE/RANK	BRANCH OF SERVICE	UNIT/ORGANIZATION			
BASE ASSIGNED	DATE ARRIVED ON STATION	TELEPHONE (WORK)			
TELEPHONE (HOME)	ADDRESS (HOME) INCLUDE CITY, STATE AND ZIP CODE				
SPONSOR IS: <input type="checkbox"/> MOTHER OF BABY <input type="checkbox"/> FATHER OF BABY <input type="checkbox"/> NEITHER					
				SPONSOR IS <input type="checkbox"/> REMOTE	<input type="checkbox"/> DEPLOYED
SPONSOR IS ACTIVE DUTY STUDENT				<input type="checkbox"/> YES	<input type="checkbox"/> NO
SPONSOR IS IN THE PERSONNEL RELIABILITY PROGRAM (PRP)				<input type="checkbox"/> YES	<input type="checkbox"/> NO
SPONSOR IS FIRST TIME PARENT				<input type="checkbox"/> YES	<input type="checkbox"/> NO
SPONSOR IS PREVIOUS NPSP CLIENT				<input type="checkbox"/> YES	<input type="checkbox"/> NO
PARTNER/FAMILY MEMBER INFORMATION					
FIRST NAME	LAST NAME	SOCIAL SECURITY NUMBER (SSN)			
DATE OF BIRTH	ETHNICITY	EXPECTED DUE DATE			
GRADE/RANK (if active duty)	BRANCH OF SERVICE (if active duty)	UNIT/ORGANIZATION (if active duty)			
BASE ASSIGNED (if active duty)	DATE ARRIVED ON STATION	TELEPHONE (WORK)			
TELEPHONE (HOME)	ADDRESS (HOME) INCLUDE CITY, STATE AND ZIP CODE				
PARTNER/FAMILY MEMBER IS: <input type="checkbox"/> MOTHER OF BABY <input type="checkbox"/> FATHER OF BABY <input type="checkbox"/> NEITHER					
RELATIONSHIP TO SPONSOR: <input type="checkbox"/> DAUGHTER <input type="checkbox"/> SPOUSE <input type="checkbox"/> OTHER: _____					
				PARTNER IS <input type="checkbox"/> REMOTE	<input type="checkbox"/> DEPLOYED
PARTNER IS ACTIVE DUTY STUDENT				<input type="checkbox"/> YES	<input type="checkbox"/> NO
PARTNER IS IN THE PERSONNEL RELIABILITY PROGRAM (PRP)				<input type="checkbox"/> YES	<input type="checkbox"/> NO
PARTNER IS FIRST TIME PARENT				<input type="checkbox"/> YES	<input type="checkbox"/> NO
PARTNER IS PREVIOUS NPSP CLIENT				<input type="checkbox"/> YES	<input type="checkbox"/> NO
CHILDREN IN THE HOUSEHOLD					
NAME	GENDER	BIRTHDATE	NAME	GENDER	BIRTHDATE
DISCLAIMER					
<p>I understand that the information in this package will be used to contact me and offer a family service plan to meet my family's needs. The information will be maintained and secured by the New Parent Support Program (NPSP) personnel using a combination of two locking devices to reduce the chance of unauthorized access. The information may also be used by medical personnel to evaluate the quality of NPSP. The information accessed through this system is FOR OFFICIAL USE ONLY and must be protected in accordance with the Privacy Act of 1974, the Health Insurance and Portability and Accountability Act, and AFI 33-332. It is obtained under legal authority of Executive Order 9397</p>					
SIGNATURE				DATE	

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
BASE \_\_\_\_\_

NPSP ID#: \_\_\_\_\_

## U.S.A.F. Family Advocacy New Parent Support Program Family Needs Screener

1. What is your military status? **(PLEASE CIRCLE)**

- ❶ Active Duty Member
- ❷ Family Member, Spouse
- ❸ Retired Military
- ❹ Family Member, Daughter
- ❺ Other **(SPECIFY)**: \_\_\_\_\_

---

2. What is the sponsor's military status? **(PLEASE CIRCLE)**

- ❶ Active Duty
- ❷ Retired Military
- ❸ Other **(SPECIFY)**: \_\_\_\_\_

---

3. What is your marital status? **(PLEASE CIRCLE)**

- ❶ Single
- ❷ Married
- ❸ Divorced
- ❹ Separated
- ❺ Widowed

---

4. What is your current living situation? Are you: **(PLEASE CIRCLE)**

- ❶ Living together with your partner/spouse
- ❷ Living alone (or with children only)
- ❸ Living with your parents (or other adults)
- ❹ Other living situation **(SPECIFY)**: \_\_\_\_\_

---

5. How long have you been living together: \_\_\_\_ Years \_\_\_\_ Months \_\_\_\_ Not Applicable

---

6. Are you currently pregnant or in the process of adoption? **(PLEASE CIRCLE)**

- ❶ Yes
- ❷ No **(GO TO QUESTION 7)**

---

(a) No. of Weeks Pregnant \_\_\_\_\_

---

7. Did you have or adopt a baby over the last 12 months? **(PLEASE CIRCLE)**

- ❶ Yes
- ❷ No

➡ **GO TO NEXT PAGE**

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

NPSP ID#: \_\_\_\_\_

8. How many children are living with you? (**SPECIFY**): \_\_\_\_\_

9. Do you have any children living with you who are from a prior relationship? (either yours or your partner's) (**PLEASE CIRCLE**)

① Yes

② No

10. What is your age? \_\_\_\_\_

11. What is your partner's age? \_\_\_\_\_ (**SKIP IF NOT APPLICABLE**)

### Ethnic Group

12. Which of these ethnic groups do you and your partner consider yourself? (**PLEASE CIRCLE**)

#### 1. YOU

①	Pacific Islander
②	Asian
③	Native Amer. Or Alaskan Native
④	White but not Latino
⑤	Black but not Hispanic
⑥	Latino or Hispanic
⑦	Multi-racial
⑧	Some other group ( <b>SPECIFY</b> ): _____

#### 2. YOUR PARTNER

①	Pacific Islander
②	Asian
③	Native Amer. Or Alaskan Native
④	White but not Latino
⑤	Black but not Hispanic
⑥	Latino or Hispanic
⑦	Multi-racial
⑧	Some other group ( <b>SPECIFY</b> ): _____

### Education

13. What is the last year of school that you and your partner completed? (**PLEASE CIRCLE**)

#### 1. YOU

①	7 <sup>th</sup> Grade or Less
②	8 <sup>th</sup> Grade
③	Some High School/GED
④	High School Graduate
⑤	Some College
⑥	College Graduate
⑦	Post-B.A. Training
⑧	Advanced Degree

#### 2. YOUR PARTNER

①	7 <sup>th</sup> Grade or Less
②	8 <sup>th</sup> Grade
③	Some High School/GED
④	High School Graduate
⑤	Some College
⑥	College Graduate
⑦	Post-B.A. Training
⑧	Advanced Degree

➡ **GO TO NEXT PAGE**

**INSTRUCTIONS: FOR EACH QUESTION, PLEASE READ THE FOLLOWING STATEMENTS AND CIRCLE THE BEST RESPONSE**

**GO TO QUESTION 17 IF YOU ARE NOT CURRENTLY PREGNANT**

	Strongly Disagree	Disagree	Agree	Strongly Agree
14. My partner is very supportive of this pregnancy.	1	2	3	4
15. This is an unplanned pregnancy.	1	2	3	4
16. This is not a good time for me to have a baby.	1	2	3	4

**GO TO QUESTION 21 IF YOU ARE NOT CURRENTLY IN A RELATIONSHIP**

17. My partner treats me well.	1	2	3	4
18. My partner and I have a very good relationship.	1	2	3	4
19. I wish my partner and I got along better.	1	2	3	4
20. I have thought seriously about ending my relationship with my partner.	1	2	3	4
21. This is a very stressful time for me.	1	2	3	4
22. At times I feel out of control, like I'm losing it.	1	2	3	4
23. Uncontrolled anger can be a problem in my family.	1	2	3	4
24. I only have a few friends/family to help with the baby (my children).	1	2	3	4
25. I feel very isolated.	1	2	3	4
26. I sometimes drink enough to feel really high or drunk.	1	2	3	4
27. I sometimes drink five or more drinks of alcohol at a time, but mostly on weekends.	1	2	3	4

**GO TO QUESTION 29 IF YOU ARE NOT CURRENTLY IN A RELATIONSHIP**

28. My partner sometimes drinks five or more drinks at a time, but mostly on weekends.	1	2	3	4
29. It is sometimes necessary to discipline a child with a good, hard spanking.	1	2	3	4
30. I can think of a situation when I would approve of a wife slapping a husband's face.	1	2	3	4
31. I can think of a situation when I would approve of a husband slapping a wife's face.	1	2	3	4
32. It is sometimes necessary for parents to slap a teen who talks back or is getting into trouble.	1	2	3	4
33. When I was a child I was spanked or hit a lot by my mother or father.	1	2	3	4

➔ GO TO NEXT PAGE

DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

NPSP ID#: \_\_\_\_\_

**INSTRUCTIONS: FOR EACH QUESTION, PLEASE READ THE FOLLOWING STATEMENTS AND CIRCLE THE BEST RESPONSE**

	Strongly Disagree	Disagree	Agree	Strongly Agree
34. When I was a teenager, I was hit a lot by my mother or father.	①	②	③	④
35. When I was growing up, I saw my mother or father hit or throw something at their partner.	①	②	③	④
36. My parents helped me when I had problems.	①	②	③	④
37. I have unhappy memories of my childhood.	①	②	③	④
38. My parents did not comfort me when I was upset.	①	②	③	④
39. My income is often inadequate for basic needs (rent, food, clothing, transportation, etc.).	①	②	③	④
40. I feel that I have a number of good qualities.	①	②	③	④
41. I feel that I am a person of worth, at least on an equal basis with others.	①	②	③	④
42. I frequently feel as if I am not as good as others.	①	②	③	④
43. I feel I do not have much to be proud of.	①	②	③	④
44. All in all, I am inclined to feel that I am a failure.	①	②	③	④
45. Someone I'm close to makes me feel confident in myself.	①	②	③	④
46. There is someone I can talk to openly about anything.	①	②	③	④
47. There is someone I can talk to about problems in my relationship.	①	②	③	④
48. I have someone to borrow money from in an emergency.	①	②	③	④
49. I have someone to take care of my child/children for several hours if needed.	①	②	③	④
50. I have someone who helps me around the house.	①	②	③	④
51. I have someone I can count on in times of need.	①	②	③	④
52. I usually wake up feeling pretty good.	①	②	③	④
53. I think good things will happen to me in the future.	①	②	③	④
54. There are times when I feel life is not worth living.	①	②	③	④
55. I feel sad quite often.	①	②	③	④
	<b>YES</b>	<b>NO</b>		
56. Have you or your partner been involved in a suspected or verified case of child abuse or neglect?	①	②		
57. Have you or your partner been involved in a suspected or verified case of spouse abuse?	①	②		

END OF QUESTIONNAIRE

Page 4 of 4

**THANK YOU**

## How Can We Help Form - Mother

### Pregnancy Issues

- ☐ Bottle Feeding Info
- ☐ Car Seat Selection
- ☐ Father's Role
- ☐ Labor and Delivery
- ☐ Nutrition
- ☐ Prenatal Bonding
- ☐ Referral to WIC/Medicaid/Food Stamps

Other:

- ☐ Breast Feeding Info
- ☐ Emotional Changes
- ☐ Fetal Growth and Dev
- ☐ Newborn Care Education
- ☐ Pregnancy and Health
- ☐ Preparation for Baby

### Child Rearing Issues

- ☐ Calming Baby
- ☐ Child Development
- ☐ Feeding
- ☐ Infant Communications
- ☐ Infant Personality
- ☐ Parent and Child Support
- ☐ Play and Activities
- ☐ Sleep Patterns
- ☐ Sudden Infant Death (SIDS)
- ☐ Toilet Training
- ☐ Sibling Rivalry
- ☐ Finding Infant Daycare

Other:

- ☐ Child Health Issues
- ☐ Discipline
- ☐ Groups
- ☐ Infant Massage
- ☐ Infant/Toddler Care
- ☐ Parenting Education
- ☐ Safety and Child Proofing
- ☐ Spoiling Baby
- ☐ Temper Tantrums
- ☐ Toy Selection
- ☐ Behavioral Problems

### Personal / Relationship Issues

- ☐ Sex / Intimacy Concerns
- ☐ Financial Management
- ☐ Loneliness
- ☐ Relationship Concerns
- ☐ Lack of Family Support
- ☐ Parenting Concerns
- ☐ TDY / Deployment / Remote
- ☐ Stress Management

Other:

- ☐ Divorce / Separation
- ☐ Grief
- ☐ Past Childhood Experiences
- ☐ Self-Esteem Issues
- ☐ Single Parenting
- ☐ Fathers Role and Involvement
- ☐ Military Lifestyle
- ☐ Immigration Issues

Signature : \_\_\_\_\_

**FAMILY ADVOCACY INFORMED CONSENT**  
**Prevention**

Family Advocacy prevention services are designed to strengthen and support the health and wellness of military families.

I understand that participation in the prevention program offered is completely voluntary and that I may choose to withdraw at any time without notice and without giving a reason.

I will be asked to participate in program assessment questionnaires. The data from these questionnaires will be analyzed as group data. Research findings NEVER include individual names or other identifying information.

I further understand there may be possible risks and benefits to participating. Possible risks: some questions may touch on personal or sensitive issues. Possible benefits: increased understanding of family issues and concerns, and skills in dealing with them; knowledge of health and self-care practices, and increased satisfaction with myself and other family members.

I understand that if at any time information I disclose has a bearing on my personal or my family's safety and/or medical needs, it may be necessary for you to communicate this information to a physician or appropriate Air Force personnel. In such a situation, I will be informed of the reasons for concern and the decision to relate this information.

The work of student professionals, technicians and volunteers providing services to my family is reviewed after each contact to ensure quality.

I have read this form and fully understand benefits and risks. I agree to participate in the program.

Signature:

Date:

I have reviewed the information on this form with the above-identified client to ensure he/she understands FAP prevention informed consent policies.

“The information accessed through this system is FOR OFFICIAL USE ONLY and must be protected in accordance with the Privacy Act of 1974, the Health Insurance and Portability and Accountability Act, and AFI 33-332.”

Signature of Witness:

Date:

## PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

*THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.*

### 1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

### 2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

### 3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

### 4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR

SSN OF MEMBER OR SPONSOR

DATE