



**Department of Health
HUGS Documentation Record**

LABEL	Population <input type="checkbox"/> Prenatal EDD: _____ <input type="checkbox"/> Postpartum <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Parent/Guardian	Location of Visit <input type="checkbox"/> Home <input type="checkbox"/> Other _____ <input type="checkbox"/> Interpreter Used: <input type="checkbox"/> Language Line _____ <input type="checkbox"/> Cert. Person _____ <input type="checkbox"/> Family/Friend _____ <input type="checkbox"/> Other _____
SUBJECTIVE: <input type="checkbox"/> Followed up with Family Goal from last visit <input type="checkbox"/> Goal achieved <input type="checkbox"/> Goal not achieved <input type="checkbox"/> Goal in progress Nutrition: <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Baby food <input type="checkbox"/> Diet recall: _____ _____ Medical Appointments: <input type="checkbox"/> Kept _____ <input type="checkbox"/> Missed Next medical appointment: _____ _____ _____		Prenatal: PN Vitamin? Y N Fetal Move? Y N S/S PTL? Y N
OBJECTIVE: Home: <input type="checkbox"/> Odor <input type="checkbox"/> Pests <input type="checkbox"/> Visible mold/ mildew <input type="checkbox"/> Inside Pets <input type="checkbox"/> Noisy <input type="checkbox"/> Evidence of substance use Status of Parent: <input type="checkbox"/> Alert <input type="checkbox"/> Listens attentively <input type="checkbox"/> Tearful <input type="checkbox"/> Distracted <input type="checkbox"/> Sleepy <input type="checkbox"/> Other: _____ Status of Infant/ Child: <input type="checkbox"/> N/A <input type="checkbox"/> Alert <input type="checkbox"/> Active <input type="checkbox"/> Playful <input type="checkbox"/> Fussy/ crying <input type="checkbox"/> Asleep <input type="checkbox"/> Other: _____ Parent/Child Interaction: <input type="checkbox"/> N/A <input type="checkbox"/> Eye Contact <input type="checkbox"/> Holding/touching <input type="checkbox"/> Smiles <input type="checkbox"/> Ignoring <input type="checkbox"/> Yelling at child <input type="checkbox"/> Anger _____ _____		
Assessed at this Visit: <input type="checkbox"/> Environment/ Safety <input type="checkbox"/> Health <input type="checkbox"/> Nutrition <input type="checkbox"/> Substance Use <input type="checkbox"/> Family Planning <input type="checkbox"/> Mental Health/ Dev. <input type="checkbox"/> Family Strengths	<input type="checkbox"/> No Problems Identified at this visit <input type="checkbox"/> Homeless <input type="checkbox"/> Abuse <input type="checkbox"/> Car Seat <input type="checkbox"/> SIDS Risk <input type="checkbox"/> Other _____ <input type="checkbox"/> Chronic Disease <input type="checkbox"/> Lack of Medical Care <input type="checkbox"/> Lack of Dental Care <input type="checkbox"/> Behind on Immunizations <input type="checkbox"/> No Insurance <input type="checkbox"/> Other _____ <input type="checkbox"/> Food Insecurity <input type="checkbox"/> Other _____ <input type="checkbox"/> Current Abuse <input type="checkbox"/> Secondhand Smoke Exposure <input type="checkbox"/> Other _____ <input type="checkbox"/> Not using method <input type="checkbox"/> Not happy with method <input type="checkbox"/> Other _____ <input type="checkbox"/> Diagnosed Mental Illness <input type="checkbox"/> Development Concerns <input type="checkbox"/> Other _____ <input type="checkbox"/> Income Concerns <input type="checkbox"/> Limited Support System <input type="checkbox"/> Other _____	
PLAN: Ed Provided: <input type="checkbox"/> Environment/ Safety <input type="checkbox"/> Health <input type="checkbox"/> Nutrition <input type="checkbox"/> Substance Use <input type="checkbox"/> Family Planning <input type="checkbox"/> Mental Health/ Dev. <input type="checkbox"/> Family Strengths <input type="checkbox"/> ASQ Completed: Mo: _____ N DEL	<input type="checkbox"/> See Referral Tracker <input type="checkbox"/> Car Seat <input type="checkbox"/> SIDS <input type="checkbox"/> Childproof Home <input type="checkbox"/> Injury Prevention <input type="checkbox"/> Other: _____ <input type="checkbox"/> Preventive Care <input type="checkbox"/> Infant Care <input type="checkbox"/> When to seek care <input type="checkbox"/> Other: _____ <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Infant/child Food Issues <input type="checkbox"/> Diet/ Exercise <input type="checkbox"/> Other: _____ <input type="checkbox"/> Use during Pregnancy <input type="checkbox"/> 2 nd hand Smoke Exposure <input type="checkbox"/> Other: _____ <input type="checkbox"/> Importance of birth spacing <input type="checkbox"/> Methods <input type="checkbox"/> Other: _____ <input type="checkbox"/> Symptoms <input type="checkbox"/> Development Milestones/ Activities <input type="checkbox"/> Other: _____ <input type="checkbox"/> Bonding <input type="checkbox"/> Finances/ Ed/ Career <input type="checkbox"/> Stress <input type="checkbox"/> Grief <input type="checkbox"/> Discipline <input type="checkbox"/> Other: _____ <input type="checkbox"/> PHBC Pages: _____ <input type="checkbox"/> See Pamphlet List <input type="checkbox"/> SAC Months: _____ <input type="checkbox"/> Other Ed. Provided _____	
NOTES: _____ _____ _____ _____		
Family Goal for next Visit: _____ _____		
Date of Next Visit: _____ Signature: _____ Date: _____		