

**SAFE CRIBS FOR MISSOURI PROGRAM  
INITIAL SESSION - ASSESSMENT**

Date \_\_\_\_\_

Client's Name \_\_\_\_\_ Maiden Name \_\_\_\_\_  
(Please Print) (Please Print)

Baby's First, Middle and Last Name (if born) \_\_\_\_\_  
(Please Print)

Baby's Gender  Male  Female      Baby's Date of Birth \_\_\_\_\_

1. Have you received previous education about Sudden Infant Death Syndrome (SIDS) or safe sleep guidelines for your baby?  
 No  Yes If yes, who? (Check all that apply)  
 Health care provider       Home visiting staff  
 Prenatal or birthing classes       Other \_\_\_\_\_
2. In what position will you lay your baby down to sleep?  
 Back  Side  Stomach  Other \_\_\_\_\_
3. If your baby is already born, in what position do you lay your baby down to sleep?  
 NA  Back  Side  Stomach  Other \_\_\_\_\_
4. Do you plan on putting anything in the portable crib with your baby other than the fitted sheet?  Yes  No  
If yes, what? (Check all that apply)  Pillow  Blankets/flat sheet  Toys/stuffed animals  
 Crib bumpers  Sleep positioner
5. Do you or would you ever put your baby alone on sofas, recliners, waterbeds, beanbag chairs, air mattresses, or adult beds?  
 Yes  No
6. Did you smoke before becoming pregnant?  No  Yes      If yes, did you quit?  No  Yes
7. Do you smoke now?  No  Yes  Smokes outside  Smokes inside
8. Does your significant other smoke?  No  Yes  Smokes outside  Smokes inside
9. Will your baby be exposed to someone smoking?  No  Yes  Smokes outside  Smokes inside
10. If others are smoking at your home, list relationship (check all that apply):  NA  
 Husband/boyfriend/baby's father/significant other       Grandparents or Great-Grandparents of your baby  
 Baby's brother or sister       Other family members  Friends or neighbors
11. Do you have family members, friends/neighbors, child care staff or significant other who will care for your baby?  Yes  No  
If yes, do you plan to share what you learn about safe sleep with them?  Yes  No      If yes, who? (Check all that apply)  
 Friend(s)/neighbor(s)       Family/relatives  Husband/boyfriend/baby's father/significant other  
 Early childhood learning center/child care       Babysitter
12. Do you know others who put their babies on their backs to sleep?  No  Yes      If yes, who? (Check all that apply)  
 Friend(s)/neighbor(s)       Family/relatives  Husband/boyfriend/baby's father/significant other  
 Early childhood learning center/child care       Babysitter
13. Have you been receiving or did you receive prenatal care?  Yes  No
14. During your pregnancy, from what source(s) did you get the most helpful information about your pregnancy and about parenting your new baby? (Check all that apply)  
 Family/relative(s)       Friend(s)/neighbor(s)       Health department/WIC  
 Health care provider (doctor, nurse, other health provider)       Formal class (prenatal, birthing, parenting)  
 Print/media (books, television, brochures, magazines, Internet)       Home or case management visit  
 Pregnancy resource center or ministry/pregnancy life line or other toll-free telephone line  
 Other \_\_\_\_\_

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Educator's Signature