

Client Name: _____

Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
--	--

Marital Status

Single
 Married
 Divorced
 Separated
 Widowed

PRIMARY CARE PHYSICIAN:

Phone: _____

Annual household income: \$ _____

Spouse Name: _____ Age: _____

Children in household 17 & under:

<u>Name</u>	<u>Age</u>
_____	_____
_____	_____
_____	_____

Fulltime students 18+ in Household:

<u>Name</u>	<u>Age</u>
_____	_____
_____	_____

EDUCATION STATUS

Highest grade completed: _____

HS Diploma/GED

Tech School

Some College

2-year College Degree

4-year College Degree

Graduate Degree

County of Residence:

Emergency contact:

First name: _____ Last name: _____

Phone: _____ Relation: _____

Client Signature: _____

Ethnicity

Cuban
 Dominican
 Hispanic - Specific Origin Not Given
 Hispanic or Latino
 Mexican
 Not Hispanic or Latino
 Not of Hispanic Origin
 Other Specific Hispanic
 Puerto Rican
 Unknown

Primary Language:

Employment Status:

Employer: _____

Full time
 part time
 unemployed/ seeking
 unemployed/ not seeking
 disabled
 retired
 Homemaker
 student

Communication preference:

Email

@ _____

text
 phone

Race

Alaskan Native
 American Indian
 Asian
 Black/African-American
 Other single race
 Pacific Islander
 Two or more races
 Unknown
 White

Military Status:

NONE
 Active
 discharged Veteran
 disabled vet
 Guard/Reserve

Living Situation:

Private Residence- adult
 Private Residence- child
 Perm supportive housing
 Residential group home
 Community residence
 Temporary housing
 Foster care
 DD Licensed/operated facility
 Correctional facility
 Homeless
 Other

Type of payment method:

Medicaid
 Medicare
 Private Insurance
 Self-Pay

Insurance Policy Holder Info:

First Last

DOB SS #

Male Female

Address: if different than client

City State zip

Date: _____