Client Name:_____

Sex
- ☐ Male
- ☐ Female

Pregnant
- ☐ Yes
- ☐ No
- ☐ N/A

Marital Status
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

PRIMARY CARE PHYSICIAN:
_____

Phone:_____

Annual household income: $_____

Spouse Name:_____ Age:____

Children in household 17 & under:

Name Age

_____

_____

_____

Fulltime students 18+ in Household:

Name Age

_____

_____

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:
_____

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*

Emergency contact:

First name: _____ Last name:_____

Phone:_____ Relation:_____

Client Signature: Date:

Form 101-Revised 3-2026

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Client Name	Date

Please answer the following questions.

PAIN ASSESSMENT:

Are you currently having any pain symptoms? ___YES ____NO If yes, explain:
Have you previously received treatment for pain symptoms? ___YES ___ NO If yes, explain:

NUTRITIONAL ASSESSMENT:

Do you have FOOD Allergies? ____YES ____NO IF YES List:
Have you had a weight loss or gain of 10 pounds in last 3 months? _____YES _____NO If YES explain:
Have you had a decrease in food intake and/or appetite? ____YES _____NO If YES explain:
Do you have any Dental Problems? _____YES _____NO If YES explain:
Do you Binge eat or induce Vomiting? _____YES _____NO If YES explain: