

Women's Health Intake

Client ID: _____

Admission ID: _____

Client's name (first, middle, last) _____ Maiden name _____

Client alias _____ Alias Client ID _____

Birth date ____/____/____ Social Security # _____ Other IDs: _____

ID Number	ID Type

Street address _____ Apt# _____ County _____

City _____ State _____ Zip code _____

Home phone _____ Work phone _____

Message phone _____ Message place _____ Message contact _____

Emergency contact _____ Phone _____ Relationship _____

Primary Race: (enter option from race table below) _____

Race: (Check all that apply)

<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Black	<input type="checkbox"/> unknown
<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Other Pacific	<input type="checkbox"/> other specify _____
<input type="checkbox"/> White		

Is participant of Hispanic/Latino descent? yes no

Country of Origin: (if Hispanic/Latino)

<input type="checkbox"/> Central America	<input type="checkbox"/> Mexico	<input type="checkbox"/> South America	<input type="checkbox"/> other specify _____
<input type="checkbox"/> Cuba	<input type="checkbox"/> Puerto Rico	<input type="checkbox"/> Unknown	

Ethnicity:

<input type="checkbox"/> African American	<input type="checkbox"/> Asian (not Vietnamese)	<input type="checkbox"/> Haitian	<input type="checkbox"/> Somalian
<input type="checkbox"/> African (not Sudanese)	<input type="checkbox"/> Asian (Vietnamese)	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> unknown
<input type="checkbox"/> African (Sudanese)	<input type="checkbox"/> Bosnian	<input type="checkbox"/> Jamaican	<input type="checkbox"/> other specify _____
<input type="checkbox"/> American	<input type="checkbox"/> Chinese	<input type="checkbox"/> Korean	
	<input type="checkbox"/> Croatian	<input type="checkbox"/> Micronesian	

Languages spoken:

<input type="checkbox"/> American Sign Language	<input type="checkbox"/> English	<input type="checkbox"/> Sudanese	<input type="checkbox"/> other specify _____
<input type="checkbox"/> Bosnian	<input type="checkbox"/> Serbian	<input type="checkbox"/> Vietnamese	
<input type="checkbox"/> Chinese	<input type="checkbox"/> Spanish	<input type="checkbox"/> unknown	

Is English the primary language? yes no unknown

Is a translator needed? yes no unknown If yes, what language? _____

Date of contact: _____

How did client hear of services? (choose all that apply)

<input type="checkbox"/> birthright	<input type="checkbox"/> juvenile court officer	<input type="checkbox"/> hospital (specify) _____
<input type="checkbox"/> care coordinator	<input type="checkbox"/> medical clinic	<input type="checkbox"/> other agency (specify) _____
<input type="checkbox"/> church	<input type="checkbox"/> other participant	<input type="checkbox"/> media (specify) _____
<input type="checkbox"/> daycare	<input type="checkbox"/> primary care provider	<input type="checkbox"/> literature (specify) _____
<input type="checkbox"/> DHS	<input type="checkbox"/> school nurse/counselor	<input type="checkbox"/> outreach (specify) _____
<input type="checkbox"/> door to door	<input type="checkbox"/> shelter	<input type="checkbox"/> other (specify) _____
<input type="checkbox"/> education/school/AEA	<input type="checkbox"/> walk-in /self-referral	
<input type="checkbox"/> family planning	<input type="checkbox"/> WIC	
<input type="checkbox"/> friend/relative	<input type="checkbox"/> unknown	

Will services be provided? yes no

If no, reason not served:

<input type="checkbox"/> eligibility guidelines not met	<input type="checkbox"/> not pregnant	<input type="checkbox"/> other specify _____
<input type="checkbox"/> out of service area	<input type="checkbox"/> services refused	

Client consent form signed? <input type="checkbox"/> yes <input type="checkbox"/> no	Date signed: ____/____/____
Subcontractor assigned: _____	County Assigned _____

Client Name: _____ Birth Date: _____ Medicaid ID: _____

Primary Payment Source: (enter option from payment source table below) _____

Secondary Payment source: (check all that apply)

<input type="checkbox"/> county funds	<input type="checkbox"/> Medipass	<input type="checkbox"/> SSI	<input type="checkbox"/> other specify _____
<input type="checkbox"/> eligible/not receiving Title XIX	<input type="checkbox"/> OB indigent	<input type="checkbox"/> Title V	
<input type="checkbox"/> Hawk	<input type="checkbox"/> presumptive eligibility	<input type="checkbox"/> uninsured	
<input type="checkbox"/> Medicare	<input type="checkbox"/> private insurance	<input type="checkbox"/> unknown	
<input type="checkbox"/> Medicaid/Title XIX	<input type="checkbox"/> self-pay/sliding scale	<input type="checkbox"/> non-billable	

WIC certified at admission? yes no unknown

Employment:

<input type="checkbox"/> full time	<input type="checkbox"/> student	<input type="checkbox"/> disabled	<input type="checkbox"/> other
<input type="checkbox"/> part time	<input type="checkbox"/> self-employed	<input type="checkbox"/> temporary	<input type="checkbox"/> unknown
<input type="checkbox"/> unemployed	<input type="checkbox"/> homemaker		

Work Hours:

<input type="checkbox"/> day	<input type="checkbox"/> nights
<input type="checkbox"/> evening	<input type="checkbox"/> varies

Current marital status:

<input type="checkbox"/> divorced	<input type="checkbox"/> parent with partner	<input type="checkbox"/> single	<input type="checkbox"/> unknown
<input type="checkbox"/> married	<input type="checkbox"/> separated	<input type="checkbox"/> widowed	

Highest grade participant completed:

<input type="checkbox"/> 8th grade or less	<input type="checkbox"/> high school graduate	<input type="checkbox"/> college degree
<input type="checkbox"/> 9th grade	<input type="checkbox"/> GED	<input type="checkbox"/> technical training
<input type="checkbox"/> 10th grade	<input type="checkbox"/> some college	<input type="checkbox"/> other
<input type="checkbox"/> 11th grade		

Health History Indicate if client or family member has a history of any of the following

Disease	Client	Family Member	Comments
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
High Blood Pressure	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
Heart Disease (including heart attack, stroke)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
Breast Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
Cervical Cancer, Uterine Cancer or Ovarian Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
Other Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
Arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
Osteoporosis	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
Lung Disease (including asthma, emphysema)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
Periodontal Disease	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
Hepatitis C or Hepatitis B	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
HIV or AIDS	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
Mental Illness (including anxiety or panic disorder, depression, bipolar disorder, schizophrenia, etc.)	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
Sexually Transmitted Diseases	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
Anemia	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	
Tuberculosis	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown <input type="checkbox"/> client declines to answer	

Client Name: _____ Birth Date: _____ Medicaid ID: _____

Health And Risk Assessment

Does client have any of the following risk factors?

- lack of or minimal physical activity
- multiple sexual partners/same sex partner/unprotected sex
- overweight/obesity
- substance abuse (alcohol or drugs)
- tobacco smoking or chewing
- underweight

Health Screenings Completed

Indicate if the client has had any of the following health screenings. If yes, enter the date of the screening.

- Mammogram yes no unknown If yes, date of screening: ____/____/____
- Clinical breast exam yes no unknown If yes, date of screening: ____/____/____
- Pelvic exam, including Pap Smear yes no unknown If yes, date of screening: ____/____/____
- Oral health assessment yes no unknown If yes, date of screening: ____/____/____
- Colonoscopy or Sigmoidoscopy yes no unknown If yes, date of screening: ____/____/____
- Fecal Occult Blood test yes no unknown If yes, date of screening: ____/____/____
- Blood pressure check yes no unknown If yes, date of screening: ____/____/____
- Bone Mineral Density test yes no unknown If yes, date of screening: ____/____/____
- Skin exam (mole, etc.) yes no unknown If yes, date of screening: ____/____/____
- Eye exam, including glaucoma screen yes no unknown If yes, date of screening: ____/____/____

Lab Work

- Thyroid test (TSH) yes no unknown If yes, date of screening: ____/____/____
- Cholesterol yes no unknown If yes, date of screening: ____/____/____
- Glucose yes no unknown If yes, date of screening: ____/____/____

Immunizations: Are the following immunizations up to date?

- Tetanus Diphtheria yes no unknown If yes, date: ____/____/____
- Influenza vaccine yes no unknown If yes, date: ____/____/____
- Pneumococcal vaccine yes no unknown If yes, date: ____/____/____
- Hepatitis B vaccine yes no unknown If yes, date: ____/____/____
- Rubella vaccine yes no unknown If yes, date: ____/____/____
- Varicella yes no unknown If yes, date: ____/____/____

General comments: _____

Intake form completed by:		
Data entered by:		
Quality assurance inspection:		