



Client Intake Form

Birth Choice Health Clinics

Today's Date:	<input type="checkbox"/> Appointment <input type="checkbox"/> Walk-in <input type="checkbox"/> Time of Arrival: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Case Number: (Office Use Only)	Client Number: (Office Use Only)
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First Name:	MI:	Last Name:	Birth Date:	Age:
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Address:	City:	State:	Zip:
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Home Phone: <input type="checkbox"/> OK to call and leave message <input type="checkbox"/> Block caller ID <input type="checkbox"/> Do not call	Cell Phone: <input type="checkbox"/> OK to call and leave message <input type="checkbox"/> OK to text me <input type="checkbox"/> Block caller ID <input type="checkbox"/> Do not call	Email: <input type="checkbox"/> OK to email me <input type="checkbox"/> Do not email me
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Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____	Race: <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> East Indian <input type="checkbox"/> Hispanic <input type="checkbox"/> Jewish <input type="checkbox"/> Native American <input type="checkbox"/> Other _____	Occupation:
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Have you been our clinic before? No Yes, When? _____ Under what name? _____ Same as Above

1. How did you hear about us? (check one)

Facebook Ad: College Paper Ad: High School Paper Ad: Phone Book Internet: Google, MSN, Yahoo, Website (please circle)
 211 Agency Other Pregnancy Center Church School: Nurse, Counselor, Teacher, Coach (please circle)
 411 Friend/Relative Flyer Sign Other _____
 800#/Hot Line

2. What outside help are you receiving? (check all that apply)

CalWorks Church Food Stamps Friends Husband Insurance
 Medicaid Other _____ Other Pregnancy Center Parents WIC

3. What are your living arrangements? (check all that apply)

Alone Boyfriend Child(ren) Father Fiancé Fiancée Foster Parents Friend
 Girlfriend Grandparents Mother Other Parents Roommates Shelter Spouse

4. How old were you when you became sexually active? _____

5. Have you ever been tested for a sexually transmitted disease? Yes No **Date last tested?** _____

Income Level: <input type="checkbox"/> Dependent <input type="checkbox"/> Unemployed <input type="checkbox"/> Welfare/SSI <input type="checkbox"/> \$0-\$14,000 <input type="checkbox"/> \$15,000-\$29,000 <input type="checkbox"/> \$30,000-\$44,000 <input type="checkbox"/> \$45,000-\$59,000 <input type="checkbox"/> \$60,000+ Number of people related to you in your household: _____	Marital Status: <input type="checkbox"/> Divorced <input type="checkbox"/> Engaged <input type="checkbox"/> Living Together <input type="checkbox"/> Married <input type="checkbox"/> Never Married <input type="checkbox"/> Remarried <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Religion: <input type="checkbox"/> Atheist <input type="checkbox"/> Buddhist <input type="checkbox"/> Christian <input type="checkbox"/> Christian (Catholic) <input type="checkbox"/> Hindu <input type="checkbox"/> Jehovah's Witness <input type="checkbox"/> Jewish <input type="checkbox"/> Mormon <input type="checkbox"/> Muslim / Islam <input type="checkbox"/> None <input type="checkbox"/> Sikhism <input type="checkbox"/> WICCA <input type="checkbox"/> Other _____	Student Status: <input type="checkbox"/> Middle School / Jr. High <input type="checkbox"/> High School <input type="checkbox"/> College or University <input type="checkbox"/> Not a Student	Education (highest level completed): <input type="checkbox"/> Jr. High <input type="checkbox"/> High School <input type="checkbox"/> GED <input type="checkbox"/> Jr. College <input type="checkbox"/> College <input type="checkbox"/> Grad School <input type="checkbox"/> Trade School
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Do you have private insurance? Yes No Will you need Medi-Cal insurance if you carry this pregnancy? Yes No

Do you have Medi-Cal? Yes No If you are eligible to receive Medi-Cal insurance benefits, Birth Choice Health Clinics will bill for reimbursement. Clients will not be charged any difference in the amount billed and the amount paid by insurance.

Today's Date:	Case Number: (Office Use Only)	Client Number: (Office Use Only)
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First Name:	Last Name:	MI:
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1. Have you ever given or received oral sex? Yes No

2. Have you ever had vaginal sex? Yes No

3. Have you ever had anal sex? Yes No

4. Have you ever been involved in any other sexual activity? Yes No

5. Do you smoke cigarettes? Yes No

If you answered "NO" to all of the above questions, you may now return this form to the receptionist.
If you answered "YES" to any of the above, please proceed.

6. Are you currently sexually active (within the last 3 months)? Yes No

7. How many sexual partners have you had in your lifetime?

8. Have your sexual partners been male, female, or both? Male Female Both

9. Did any of your partners have previous partners? Yes No Unsure

10. Do you currently have a primary sexual partner? Yes No

11. Does your partner have sex only with you? Yes No

12. What do you typically do to prevent diseases?

13. What do you typically do to prevent an unplanned pregnancy?

14. Is any of your sexual activity ever combined with the use of alcohol or drugs? Yes No

15. Who usually initiates your sexual activities? You Partner Both

16. Have you ever had the following STDs and when?

Chlamydia Yes No Unsure Date Tested _____

Gonorrhea Yes No Unsure Date Tested _____

Syphilis Yes No Unsure Date Tested _____

HPV / Genital Warts Yes No Unsure Date Tested _____

Hepatitis Yes No Unsure Date Tested _____

Genital Herpes Yes No Unsure Date Tested _____

HIV / AIDS Yes No Unsure Date Tested _____

Trichomoniasis Yes No Unsure Date Tested _____

Other Yes No Unsure Date Tested _____

17. Have you experienced any problems or do you have any concerns about your sexual experiences? Yes No