



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) |
|----------------------|--|---|--|--|

| | | | | |
|--------------------|------------|-------------------|--------------------|-------------|
| First Name: | MI: | Last Name: | Birth Date: | Age: |
|--------------------|------------|-------------------|--------------------|-------------|

| | | | |
|-----------------|--------------|---------------|-------------|
| Address: | City: | State: | Zip: |
|-----------------|--------------|---------------|-------------|

| | | |
|--|---|--|
| 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 |
|--|---|--|

| | | |
|---|---|--------------------|
| 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: |
|---|---|--------------------|

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 |
|--|--|--|---|---|

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) |
|---------------|-----------------------------------|-------------------------------------|

| | | |
|-------------|------------|-----|
| First Name: | Last Name: | MI: |
|-------------|------------|-----|

1. When was the first day of your last period? (mm/dd/yyyy) :

2. Was your last period normal? Yes No Unknown

3. Is your period regular? Yes No Unknown

4. What symptoms are you having? (Check all that apply)

Appetite Change Dizziness Frequent Urination Frequently Tired
 Nausea Swollen or sore breasts Weight Gain or Loss Headaches

5. Are you using Birth Control? (Check all that apply)

Condom Depo-Provera Diaphragm Foam/Gel
 IUD Natural Family Planning (Rhythm Method) Norplant Ortho-Evra (Patch)
 Other Pill Sterilization No

6. If you are not using Birth Control, did you want to get pregnant? Yes No Undecided

7. Are you having medical problems? Yes No If yes, please list:

8. Are you suffering from any illness? Yes No If yes, please list:

9. Are you on any kind of medication? Yes No If yes, please list:

10. Are you using drugs or alcohol? Yes No If yes, please list:

11. Are you a cigarette smoker? Yes No

12. Are you experiencing any kind of stress? Yes No

13. Is this potential pregnancy due to rape or sexual abuse? Yes No

14. Are you a victim of abuse? (check all that apply)

Mental/Verbal Physical Rape Sexual No

15. If your test is positive, what are your intentions? Abort Carry to Term Undecided

16. If you plan to carry to term, what are your intentions? Adoption Parent Undecided

17. What is the potential father's name? _____ Age? _____ Birth Date? _____

18. If the test is positive, will he be involved? Yes No Unsure

19. Are you looking for a future with him? Yes No Unsure

20. Does he know that you might be pregnant? Yes No Unsure

| | | | |
|----------------------|----------------------------|-------------------------|--------------------|
| # prior births _____ | # prior miscarriages _____ | # prior abortions _____ | # weeks @ AB _____ |
|----------------------|----------------------------|-------------------------|--------------------|