Center for Black Women's Wellness, Inc.
Client Information Form

All information is kept strictly confidential

Date of Service: | New Patient? Yes [ ] No [ ]

First name: | MI: | Last Name:

Date of Birth: | Age: | Gender: M[ ] F[ ] | Social Security #:

Address: | Apt/Unit #:

City: | State: | Zip: | County:

Home Phone: | Work Phone | Cell Phone | Email:

Race/Ethnicity:
[ ] Black/African American
[ ] Asian
[ ] Caucasian
[ ] Hispanic
[ ] Native American
[ ] Other_________

Marital Status:
[ ] Single
[ ] Married
[ ] Separated
[ ] Divorced
[ ] Widowed
[ ] Cohabitating

Education :(Indicate highest level completed)
[ ] Elementary(grades 1-8)
[ ] High School (grade ____)
[ ] HS Diploma
[ ] Vocational Training
[ ] Some College
[ ] Bachelors Degree
[ ] Graduate Degree

Source of Income: (check all that apply)
[ ] Full-Time Employment [ ] Child Support
[ ] Part Time Employment [ ] VA
[ ] TANF [ ] Private Disability
[ ] Self Employed [ ] Other __________
[ ] SSI/SS ___________________

Payment Method:
[ ] Self Pay (credit card, money order) [ ] Medicaid
[ ] PeachCare [ ] Medicare

Insurance Status
[ ] Uninsured [ ] Medicaid [ ] Medicare
[ ] Private Insurance

Estimate of Total Household Income:
[ ]Less than $10,999 [ ]$11,000 to $19,000 [ ]$20,000 to $29,999 [ ]$30,000 to $39,999
[ ]$40,000 to 49,999 [ ]50,000 and up [ ]Unknown

Total Number of person(s) living in your household, including yourself:__________ | Do you have children in your household under the age of 19? Yes [ ] No [ ]

List all living persons in household (first and last name)	Male/Female	Age	Your relationship to this person (spouse/parent/grandparent/sibling/ adoptive parent, aunt, etc.)

What service are you here for today?
[ ] Wellness Clinic [ ] Safety Net Clinic
[ ] Askable Adult [ ] Shots
[ ] WESSP Program [ ] Pregnancy Test
[ ] WIC Certification [ ] Atlanta Healthy Start

Have you ever received services from CBWW? Yes [ ] No [ ]
If no, how did you find out about us?
[ ] Friend/Relative [ ] Newspaper/Magazine
[ ] Clinic/Hospital [ ] Other ______________________
[ ] Internet

Emergency Contact (someone not living with you)

Name: | Relation:

Address: | Apt/Unit#:

City: | State: | Zip: | County:

Home Phone: | Work Phone:

**Thank you very much for completing this form for our funders*

Signature of Person Completing Form: ____

To reduce wait time, please complete this form IN ITS ENTIRETY and submit to the front desk PRIOR TO starting all other forms. Thank you for your cooperation.

SAFETY NET CLINIC
Health History Questionnaire

Date: _______/_______/_______

Chart#: ________

Name: ____ Date of Birth: _____/_____/_____

Address: ____

City: _________________________ State: _____ Zip: ________ SS#: ________ - _____ - ________

Telephone: ______________________________ (Home) ______________________________ (Cell)

Emergency Contact __________________________ Relationship: ______________

Address: ____ Telephone: _________________

How did you hear about the Safety Net Clinic? ____

Why are you visiting here today? ____

PERSONAL MEDICAL HISTORY

Check ☒ symptoms/conditions you currently have or have ever had in the past

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies/Hay Fever
- ☐ Anemia (low blood)
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Benign Prostatic Hypertrophy
- ☐ Bipolar Disorder
- ☐ Bleeding Disorders/Bruising
- ☐ Bladder Infections
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer *Type* ______________
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy (fits, seizures)
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease/Infections
- ☐ Lactose Intolerance
- ☐ Leg Pain
- ☐ Liver Disease
- ☐ Lupus
- ☐ Menopause
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pelvic Inflammatory Disease
- ☐ Pneumonia
- ☐ Prostatitis
- ☐ Sarcoidosis
- ☐ Schizophrenia
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Stomach Problems/ Ulcers
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urethritis
- ☐ Uterine Fibroids
- ☐ Varicose Veins

- ☐ Other ___________________

SYMPTOMS/CONDITIONS

Check ☒ symptoms you currently have or have had in the past month.

General

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Frequent Headaches
- ☐ Frequent Tiredness
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Loud snoring
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Thirst

Gynecological (Women Only)

- ☐ Breast lump
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Pain during sex
- ☐ Unpleasant vaginal odor
- ☐ Vaginal discharge
- ☐ Vaginal infections
- ☐ Vaginal itching or burning

Muscle/Joint/Bone

Pain, weakness, numbness or tingling in:

- ☐ Arms
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

Eye, Ear, Nose, Throat, Lungs

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos
- ☐ Wheezing

Urinary

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Penile discharge
- ☐ Strong urge to urinate
- ☐ Urinating more than 3 times a night

Cardiovascular

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

Gastrointestinal

- ☐ Appetite poor
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

Skin

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won’t heal

List the medications that you are currently taking.

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Are you allergic to any foods or medicines? ☐ Yes ☐ No

If yes, what items? What happens to you when exposed to these items? ______________________________________
____

Have you ever been hospitalized? ☐ Yes ☐ No If yes:

Year __________________ Reason ____

Year __________________ Reason ____

Year __________________ Reason ____

Have you ever had surgery? ☐ Yes ☐ No If yes:

Year __________________ Procedure ____

Year __________________ Procedure ____

Year __________________ Procedure ____

How many times a week do you exercise? _____ What types of exercise(s) do you do? ________________________

How would you describe your health on a scale of 1 to 10 (1 being poor and 10 being excellent)?

1 2 3 4 5 6 7 8 9 10

poor **excellent**

FAMILY HISTORY

Does anyone in your family have the following conditions? Relationship (mother, father, brother, sister, child)?

Allergies ( ) ____

Asthma ( ) ____

Dementia ( ) ____

Diabetes ( ) ____

Heart Disease ( ) ____

High Blood Pressure ( ) ____

Kidney Disease ( ) ____

Tuberculosis ( ) ____

Cancer – What type? ( ) ____

SEXUAL HISTORY

Have you ever had any of the following?

☐ Gonorrhea
☐ Chlamydia
☐ Trichomonas
☐ Herpes
☐ Syphilis
☐ Yeast
☐ Bacterial Vaginosis
☐ Human Papiloma Virus (HPV)

Have you ever had sex with?

☐ Men
☐ Women
☐ Both

Have you ever had sex with someone who is an IV drug user, or who is bisexual or gay? ☐ Yes ☐ No

Are you experiencing any problems with sexual intercourse? ☐ Yes ☐ No

If yes, what and how often? ______________________
____

Do you use condoms to protect yourself from STDs (Sexually Transmitted Diseases)? ☐ Yes ☐ No

If not, why not? ______________________________
____

OB/GYN HISTORY (Women Only)

General

Have you ever had a pap smear? ☐ Yes ☐ No

Date of last pap smear _____/_____/_____

Have you ever had an abnormal pap smear?
☐ Yes ☐ No
If yes, when and where were you treated?
_____/_____/_____ ____________________

Do you do breast self-exams every month?
☐ Yes ☐ No
If no, how often? ______________________

Do you have any discharge from your breasts?
☐ Yes ☐ No

Do you have any breast masses or lumps?
☐ Yes ☐ No

Date of last mammogram? _____/_____/_____
☐ Normal Results
☐ Abnormal Results

Are you sexually active? ☐ Yes ☐ No

Menstrual History

Age you were when periods started _______

Have you gone through menopause?
☐ Yes ☐ No

Are your periods regular?
☐ Yes ☐ No ☐ Varies

Date of last period _____/_____/_____

How many days are your there from the start of one period to the beginning of the next? _______

How many days do your periods last? _______

Flow: ☐ Light ☐ Medium ☐ Heavy

Describe the intensity of pain you experience with your periods: ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Crippling

Do you have bleeding or spotting between your periods?
☐ Yes ☐ No

Do you have bleeding or spotting after sex?
☐ Yes ☐ No

Birth Control

What method(s) for birth control do you currently use? ____

Have you ever taken birth control pills?
☐ Yes ☐ No

If yes, when and for how long? _________________
____

Other form(s) of birth control you have used:
____
____

Pregnancy History

Have you ever been pregnant? ☐ Yes ☐ No

If yes, how many times have you been pregnant? __

Have you ever had an abortion? ☐ Yes ☐ No
If yes, how many? ____________
When? _____ _____ _____ _____ _____

How many children do you have? _______

Do you breastfeed? ☐ Yes ☐ No

Have any of your children died?
☐ Yes How many? _______ ☐ No

Were any of your children premature?
☐ Yes ☐ No

Have you ever had a miscarriage, stillborn child, or abortion? ☐ Yes ☐ No

How old were you when you had your first child?
____

Do you have infertility problems? ☐ Yes ☐ No

If yes, please describe: ________________________
____
____

SOCIAL HISTORY

What is your current work status?
- ☐ Unemployed
- ☐ Part-Time job
- ☐ Full-Time job

What is the highest grade level you have completed?
- ☐ Elementary (grades 1 – 8)
- ☐ High School (grades 9 – 12)
- ☐ GED
- ☐ HS diploma
- ☐ Vocational training
- ☐ Some college
- ☐ Bachelor's degree
- ☐ Graduate degree

Do you smoke cigarettes or cigars? ☐ Yes ☐ No
If yes, how many per day? ________
If yes, for how many years? _______

Do you chew tobacco? ☐ Yes ☐ No
If yes, how often per day? ________

Do you drink beer, wine or liquor? ☐ Yes ☐ No
If yes, do you do so: ☐ Daily ☐ Weekly
☐ Monthly ☐ Every now and then
For how many years? ________

Do you use any of the following drugs?
To answer please use the codes below:
Past/Current (P/C)
Daily/Weekly/Monthly/Every Now & Then (D/W/M/E)
For how many years?

Crystal Meth: ☐ Yes ☐ No
If yes: ______ ______ ______
P/C D/W/M/E # of years

Marijuana/Blunts: ☐ Yes ☐ No
If yes: ______ ______ ______
P/C D/W/M/E # of years

Heroin: ☐ Yes ☐ No
If yes: ______ ______ ______
P/C D/W/M/E # of years

Crack: ☐ Yes ☐ No
If yes: ______ ______ ______
P/C D/W/M/E # of years

Cocaine: ☐ Yes ☐ No
If yes: ______ ______ ______
P/C D/W/M/E # of years

Have you ever been kicked, hit, or punched by your spouse/boyfriend/girlfriend/partner?
☐ Yes ☐ No
If yes, when _____/_____/_____
If yes, are you still dating or living with this person?

Have you ever been forced to have sex? ☐ Yes ☐ No
If yes, at what age? _______

NUTRITION HISTORY

How many fruits and vegetables do you usually eat each day?
0 – 2 _______ 3 – 5 _______ 6 or more _______

How many servings of caffeine (e.g. coffee, tea, Coke) do you have a day?
None _______ 1 – 3 _______ 4 – 6 _______ more than 6 _______

YOUR HEALTH INTERESTS

Are you interested in attending workshops, seminars, or classes on any of the following health topics? Check all that apply.

- ☐ Aerobics/Exercise
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Disease/Hypertension
- ☐ Nutrition/Diet
- ☐ Smoking Cessation