

Center for Black Women's Wellness, Inc/ Dunbar Teen Clinic

Client Information Form

All information is kept strictly confidential.

Chart No.:		Date of Service:		New Patient: yes [] no []			
First Name:			MI:	Last Name:			
Date of Birth:		Age:	Gender: M__ F__	Social Security #: - - -			
Address:					Apt#:		
City:		State:	Zip:	County:			
Neighborhood: <input type="checkbox"/> Adair Park <input type="checkbox"/> Mechanicsville <input type="checkbox"/> Pittsburgh <input type="checkbox"/> Peopletown <input type="checkbox"/> Summerhill <input type="checkbox"/> Other _____							
Home Phone:		Work Phone:		Email:			
Race/Ethnicity: <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other _____		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Cohabiting		Education (indicate highest level completed): <input type="checkbox"/> Elementary (grades 1-8) <input type="checkbox"/> High School (grade ____) <input type="checkbox"/> HS Diploma/GED <input type="checkbox"/> Vocational Training <input type="checkbox"/> Some College <input type="checkbox"/> Bachelors Degree <input type="checkbox"/> Graduate Degree		Source of Income (check all that apply): <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> TANF <input type="checkbox"/> Self-employed <input type="checkbox"/> SSI/SS <input type="checkbox"/> Child Support <input type="checkbox"/> VA <input type="checkbox"/> Private Disability Other _____	
Payment Method: <input type="checkbox"/> Self-pay (credit card, money order) <input type="checkbox"/> Medicaid <input type="checkbox"/> PeachCare <input type="checkbox"/> Medicare							
Estimate of total household income: <input type="checkbox"/> Less than \$10,999 <input type="checkbox"/> \$11,000 to \$19,999 <input type="checkbox"/> \$20,000 to 29,999 <input type="checkbox"/> \$30,000 to 39,999 <input type="checkbox"/> \$40,000 and over <input type="checkbox"/> Unknown							
Total number of person(s) living in your household, including yourself: _____				Do you have children? ____ yes ____ no			
List persons living in household (first and last name)				Male/ Female	Age	Education Status	
				Your relationship to this person (spouse/parents/grandparent/sibling/ Adoptive parent, aunt, etc.)			
What service are you here for today? <input type="checkbox"/> CBWW <input type="checkbox"/> Teen Clinic <input type="checkbox"/> Wellness Clinic <input type="checkbox"/> Shots <input type="checkbox"/> Askable Adult <input type="checkbox"/> EED <input type="checkbox"/> WESS Program <input type="checkbox"/> Pregnancy Test <input type="checkbox"/> EB305 Detox <input type="checkbox"/> Other _____ <input type="checkbox"/> WIC/Certification				Have you ever received services from CBWW? <input type="checkbox"/> yes <input type="checkbox"/> no If no, how did you find out about us? _____ -----Dunbar Teen Clinic Clients----- Have you ever received services from this teen clinic? <input type="checkbox"/> yes <input type="checkbox"/> no Have you ever received services from another teen clinic? <input type="checkbox"/> yes <input type="checkbox"/> no If here for shots, do you have shot record? <input type="checkbox"/> yes <input type="checkbox"/> no			
Emergency Contact (someone not living with client)							
Name:				Relation:			
Address:					Apt#:		
City:		State:	Zip:	County:			
Home Phone:			Work Phone:				

Signature of Person Completing Form: _____