INGRAHAM TEEN HEALTH CENTER

Today's Date______________________________ **Student ID** #____

What services are you here for today? ◻ Family Planning ◻ Primary Care ◻ Mental Health

Name First________________________ Last________________________________Middle Name___________________ Suffix Jr, Sr, I, II, III

Preferred Name or "Nickname"____________________________ **Social Security Number** __________-_________-____________

Gender ________________________ **Date of Birth** ____

Address____**City**___________________________**State**_______ **Zip Code** _____________

Home Phone____May we call you at this number? ◻ Yes ◻ No

Cell Phone____May we call you at this number? ◻ Yes ◻ No

Language Do you need an interpreter? ◻ Yes ◻ No If Yes, what is your primary language?___________________________

Housing Status Have you been in safe and stable housing for the past year? ◻ Yes ◻ No
If "No" ◻ Transitional housing ◻ Living with others ◻ Shelter ◻ Street/Camp/Bridge
◻ Other please describe____

Ethnicity ◻ Hispanic/Latino ◻ Non-Hispanic/Latino ◻ Decline to answer

Race Please check all that apply ◻ Asian ◻ Alaskan Native ◻ American Indian ◻ Black or African American
◻ Pacific Islander ◻ Hawaiian Native ◻ White ◻ Decline to answer

Primary Care Provider Do you have a current Primary Care Provider ◻ Yes ◻ No
If yes, who is your provider?____

Insurance Information Do you have any type of medical or dental insurance coverage?
◻ **Yes** (please provider medical insurance card at check-in) ◻ **No** If yes, please check all that apply
◻ Medicaid (**Apply Health**) ◻ Commercial Insurance ◻ Other____

Emergency Contact

Name____Relationship____

Legal Guardian □ Yes □ No Phone#______________________________Alternate Phone#_____________________________________

If No Who Is?

____

Please answer the health history questions if you know (Medial/Mental Health History)

Does the student have any medical problems or mental health concerns?

____

Does the student have any allergic to any medications?

____

Does the student need medication on a regular basis?

____

If yes what medication?

____

Has anyone in the students family had the following (**check all that apply**) for any positives please indicate who (i.e. brother, aunt, plus age onset)

_____________ Asthma __________ Diabetes ______________ Heart Problems/Stroke _____________Mental Health Problems

______________Alcohol or Chemical use ________________ Cancer _________ Seizures ____________High Blood Pressure

_____________ High Cholesterol __________________ expired before 50