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 orAfrican American
◻ Pacific Islander ◻ Hawaiian Native ◻ White ◻ Decline to answer

When is your last physical exam? Date: __________________ **When is your last dental exam**? Date:_______________

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