Name: _____ Date: _____

Client Information Form- Adult

In a few words or sentences what help, or services do you need from OneEighty? How can we help you? _____
_____

Demographic Information

Gender:

Female Trans Female Male Trans Male Decline to answer Other

Pronouns:

She/Her/Hers He/Him/His They/Them/Theirs Ze Other

Date of Birth: _____ **SSN**: _____

Marital Status:

Single/Never Married Separated Married/Living together as Married
Divorced/Annulled Widowed

Race:

Alaska Native American Indian Asian Black/African American
Caucasian/White Native Hawaiian/Other Pacific Islander
Other single race Two or more races

Ethnicity:

Cuban Hispanic-Specific Origin not given Mexican Not of Hispanic Origin
Puerto Rican Other Specific Hispanic

Living Situation:

Private Residence (rent or own) Friends or Family Home Foster Care
Homeless/lacking a permanent Residence Jail/Correctional Facility
Permanent Supportive Housing Residential Care/Group Home/ACF
Community Residence Temporary Housing Mental Health Institution
Nursing Home DD Licensed/Operated Facility Other Institution

Number of Children in the household under 18: _____

Current Life Stressors: Mark all that apply

Financial Family Job Health Issues Housing Difficulties
Legal Trouble Chronic Pain Grief/Loss Recent Trauma (i.e. victim of crime, abuse, natural disaster) Other: _____

Name: _____ Date: _____

Any Current Physical Disabilities/Limitations: Yes No
If yes, describe: _____

Do you need any assistive devices or interpreters to participate in services: Yes No
If yes, describe: _____

What is the best way to communicate (reminders, changes in schedule):
Phone call Text Message Email Other
Phone Number: _____ Email: _____

Would you like to list someone as an Emergency Contact: Yes No
If yes provide Name: _____ Relationship: _____
Phone number: _____

Health History

Primary Care Physician or Business name: _____
Date of last examination: _____

Medications <u>currently</u> being taken:

Name	Dose	How long Taken	Prescribing Physician	Effectiveness

Medications <u>previously</u> taken:

Name	Dose	How long Taken	Prescribing Physician	Effectiveness

Do you take any OTC (over the counter) medications? Yes No
If yes, what do you take: _____
_____

Allergies (drug or food): _____

Childbirth History (Skip if not applicable):

Currently Pregnant: Yes No 1st Trimester 2nd Trimester 3rd Trimester
If yes, are you receiving prenatal care or do you need assistance? _____

Childbirth within the last 5 years: Yes No **Total Number of births (live & still)**: ____

Name: _____ Date: _____

Physical Health Issues: Please indicate if you currently have, or have ever had, any of the following physical health issues. Select any that apply:

Anemia Arthritis Asthma Back Problems
Bronchitis/Emphysema Cataracts Cancer Diabetes
Hay fever/allergy Headaches Heart Disease Hearing loss
Hepatitis/Liver DX High Blood Pressure Kidney/Renal DX
Pneumonia Seizure/Epilepsy Sinus Problems Skin Disease
Stroke Thyroid Disease Tuberculosis Tumors
Ulcers Vascular Dx Vision Problems Other (complete next line)
List other significant Physical Health issues and date when occurring: _____
_____

Significant weight loss/gain in the last year: Yes No
If yes, how much change? Gained 10lbs gained 20lbs gained 30 or more lbs
lost 10lbs lost 20lbs lost 30 or more lbs

Hospitalizations in the last 3 years: Yes No
If yes, please complete:

Hospital name	Location (City)	Date(s)	Reason

Emergency Room Visits in the last year: Yes No
If yes, please complete:

Hospital name	Location (City)	Date(s)	Reason

Do you <u>currently</u> use any of the following:
Tobacco Products: Yes No If yes, please complete the following:
What products: Cigarettes Chew Cigars Vape
How much used and length of use (#packs/#years): _____
Coffee, Tea, Cola: Yes No If yes, how much: _____

Have you <u>previously</u> used any tobacco products: Yes No
If yes, please explain: _____

Do you have any health concerns not listed on this form? Yes No
If yes, please explain: _____

Do you use any Complementary Health Practices (natural products, yoga, non-traditional healers, etc)? Yes No If yes, please explain: _____

Do you have any difficulties with Activities of Daily Life (bathing, dressing, obtaining meals)?
Yes No If yes, please explain: _____