

Healing in His Wings, Inc.

Basic Client Demographic Sheet

Chart No:	Date of Service:	New Patient: <input type="radio"/> Yes <input type="radio"/> No	
	First Name:	Last Name:	MI:
Date of Birth:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security #:
Street Address:			Apartment #:
City:	State:	Zip code:	County:
Home Phone:	Work Phone		Cell Phone:
E-Mail:		Emergency Contact Name:	
		Emergency Contact Number:	
		Emergency Contact Relationship:	
		Emergency Contact Address:	
Race/Ethnicity:	Household Type:	Education:	Source of Income:
<input type="radio"/> Black/African American <input type="radio"/> Hispanic <input type="radio"/> Native American <input type="radio"/> Asian <input type="radio"/> Haitian <input type="radio"/> West Indian <input type="radio"/> African <input type="radio"/> Other _____	<input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed <input type="radio"/> Cohabiting	<input type="radio"/> Elementary(1-8) <input type="radio"/> High School (grade____) <input type="radio"/> HS Diploma/GED <input type="radio"/> Vocational Training <input type="radio"/> Some College <input type="radio"/> BS/BA Degree <input type="radio"/> Graduate Degree	<input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> TANF <input type="radio"/> Self-Employed <input type="radio"/> SSI/SS <input type="radio"/> Other _____
		Insurance Status: <input type="checkbox"/> None <input type="checkbox"/> Private	
		____ Medicaid _____ Medicare	
Estimate of total household income:			
___ Less Than \$10,999 ___ \$11,000 to \$19,999 ___ \$20,000 to \$29,999 ___ \$30,000 to 39,999 ___ \$40,000 and above			
Total number of persons in your household including yourself: _____			Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No

List person(s) living in household (first and last name)	Age:	Sex:	Grade	Relationship:

What services are you here for today?
 Wellness Clinic
 OB Care
 Family Planning
 TB Test
 Drug Screen
 B/P Check
 Pre-Employment Physical
 Pregnancy Test
 Health Education
 Other

Signature of person completing form: