EAC Intake **Volunteer: _______ Pt / Room #: ________** **New Pt** Y / N **Spanish** Y / N

First Name **Last Name**	**Birthdate**	**B/N 50-64?** Y / N
Reason for Visit	**MD student + Physician**	

Sex at Birth:	**Gender:**	**Veteran:**	**Primary Language:**
Female Male	Man Woman Transgender/Transsexual Other/Don't Know Would rather not say	Yes No	English Other ___________

Race/Ethnicity:	**Marital Status:**	**Current Housing/ Shelter:**
White Black/African American Hispanic/Latino Indian Asian Pacific Islander Other __________________	Single (Never married) Married Separated Divorced Widowed	Apartment/ House Friend/ Relative Hotel/Motel Halfway House Drug Rehab Street/ Car Homeless Shelter *How long homeless?* _________ **Number in household:**

Street Address	**Apt. No.**	**City**	**State**	**Zip Code**

Email:

Best phone to reach in two weeks?	**Alternate phone number?**	**Best time / day to call?**

Employment:	**Occupation:**	**Highest Level of Education:**	**US Citizen?**
Not Employed Full Time Part Time Retired Student		None Some College 6th – 8th Grade Associates Degree 9th-11th Grade Bachelor's Degree HS Grad/GED Graduate School Vocational School	**Yes** **No:** _________

Medical Insurance:	**How did you get to Clinic?**	**How did you hear about us?**
None VA benefits Medicaid insurance Private Medicare	I drove myself I took a bus I rode a bike I walked I got a ride from somebody else Other __________________	

Are you younger than 50? Y / N	**Have you had a colonoscopy in the last 10 years?** Y / N	(If both answers are no) **If offered, would you be interested in a free colorectal screening?** Y/ N
Do you currently smoke? Y / N		(If yes) **Are you interested in help with quitting?** Y / N
Do you have pain or problems with movement due to injury, overuse or health issues? Y / N		(If yes) **Are you interested in free physical therapy?** Y / N

Have you been tested for HIV in the last 6 months? Y / N	(If no) **Are you interested in receiving a free HIV test here today?** Y / N
Do you drink alcohol? Y / N	**If so, how many drinks / week?**

During the past month, have you often been bothered by feeling little interest or pleasure in doing things? Y / N	**Have you often felt down, depressed, or hopeless?** Y / N
During the past month, have you frequently been bothered by feeling worried or anxious most of the time? Y / N	**Have you had an anxiety attack suddenly feeling fear or panic?** Y / N

Do you feel safe in your current living situation?	Y	N
Have you ever had a partner try to control you?	Y	N
Have you ever had a partner that you were afraid of?	Y	N
Have you ever had a partner who has threatened you?	Y	N

Do you see a gynecologist regularly? Y / N	
Have you gotten a PAP smear in the last year? Y / N	**Have you had a mammogram in the last 2 years?** Y / N
Based on this info, is the patient interested in learning more about EAC Women's Night? Y / N	

How many medications are you currently taking? _____

Names:

Have you been hospitalized in the past 30 days? Y / N

Have you ever been told by a healthcare provider that you have one of the following? (circle all that apply)		
Anxiety or Depression (circle specific)	Headaches	Post-Traumatic Stress Disorder
Arthritis	Heart Disease	Schizophrenia
Asthma	Hepatitis	Seizure
Bipolar Disorder	High Blood Pressure	Sexually Transmitted Disease
Chest Pain	High Cholesterol	Stroke
Diabetes	HIV/AIDS	Kidney Disease
COPD	Other notable conditions:	

If the clinic did NOT exist how likely would you be to go to the Emergency Room for this health issue?
Very likely Somewhat Likely Neutral Very unlikely Does not apply

Have you made fewer visits to the Emergency Room in the last 6 months because of this clinic?
Yes No N/A

Have you ever had to go to the Emergency Room because you could not be seen by a doctor or clinic?
Yes No N/A

Weight	**Height**	**BMI**	**Temp**
BP	**Pulse**	**O2 Sat**	**Respirations**