

DATE: _____

FIRST NAME MIDDLE INITIAL LAST NAME / / M | F - - -
DATE OF BIRTH SEX SOCIAL SECURITY #

() () ()
CELL NUMBER HOME NUMBER WORK NUMBER

ADDRESS CITY STATE ZIP CODE

EMAIL ADDRESS PREFERRED NAME (if different from above) TYPE (birth, maiden, alias, preferred)

PROVIDER SEEN MOST OFTEN: _____

PREFERRED APPOINTMENT REMINDER METHOD: (circle one) NO REMINDER PHONE CALL TEXT MESSAGE

EMPLOYER:

EMPLOYER PHONE NUMBER OCCUPATION

ADDRESS CITY STATE ZIP CODE

I ALLOW THE FOLLOWING DISCLOSURE OF HEALTHCARE INFORMATION TO THE FOLLOWING CONTACTS. THIS AUTHORIZES STAFF TO SPEAK TO THE LISTED CONTACTS FOR ALL APPOINTMENTS, CLINICAL INFORMATION AND FINANCIAL INFORMATION.

CONTACTS:

PRIMARY CONTACT RELATIONSHIP: _____ () ()
PHONE NUMBER TYPE (CELL / HOME)

FIRST NAME LAST NAME ADDRESS CITY STATE ZIP CODE

SECONDARY CONTACT RELATIONSHIP: _____ () ()
PHONE NUMBER TYPE (CELL / HOME)

FIRST NAME LAST NAME ADDRESS CITY STATE ZIP CODE

GUARANTOR (Responsible party for payment). Complete only if the responsible party is NOT the patient. / / - - -
DATE OF BIRTH SOCIAL SECURITY #

FIRST NAME LAST NAME ADDRESS CITY STATE ZIP CODE

SIGNATURE _____ _____ _____
PATIENT'S SIGNATURE / LEGAL GUARDIAN DATE TIME

WITNESS DATE TIME

2026

Date: _____ Name: _____ DOB: _____

THIS IS ONLY A SURVEY. This information is only used to gain insight into the needs of our patients. Please circle the family size and monthly income that best represents your household.

Family Size	Level 1	Level 2	Level 3	Level 4
1	0	1,331	1,996	Over
	1,330	1,995	2,660	2,660
2	0	1,804	2,706	Over
	1,803	2,705	3,607	3,607
3	0	2,278	3,416	Over
	2,277	3,415	4,553	4,553
4	0	2,751	4,126	Over
	2,750	4,125	5,500	5,500
5	0	3,224	4,836	Over
	3,223	4,835	6,447	6,447
6	0	3,698	5,546	Over
	3,697	5,545	7,393	7,393
7	0	4,171	6,256	Over
	4,170	6,255	8,340	8,340
8	0	4,644	6,966	Over
	4,643	6,965	9,287	9,287
9	0	5,118	7,676	Over
	5,117	7,675	10,233	10,233
10	0	5,591	8,386	Over
	5,590	8,385	11,180	11,180
11	0	6,064	9,096	Over
	6,063	9,095	12,127	12,127
12	0	6,538	9,806	Over
	6,537	9,805	13,073	13,073
13	0	7,011	10,516	Over
	7,010	10,515	14,020	14,020
14	0	7,484	11,226	Over
	7,483	11,225	14,967	14,967
15	0	7,958	11,936	Over
	7,957	11,935	15,913	15,913

ADULT HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date of birth: _____

Have you personally ever had any of the following conditions:

- | | | |
|---|--|---|
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Asthma | <input type="checkbox"/> Degenerative Disk Dx |
| <input type="checkbox"/> Transfusion Reaction | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Respiratory Disorders | <input type="checkbox"/> Musculoskeletal Disorder |
| <input type="checkbox"/> MRSA | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> VRE | <input type="checkbox"/> GERD | <input type="checkbox"/> Diabetic Ketoacidosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Other GI Disorders | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Endocrine Disorders |
| <input type="checkbox"/> Genetic Disorder | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Birth Defect | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Depression |
| <input type="checkbox"/> CVA | <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Genitourinary Disorder | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> STDs | <input type="checkbox"/> Mental Health Problems |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pelvic Inflammatory Dx | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Behavior Problems |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Pregnancy Complication | <input type="checkbox"/> Eye Injury |
| <input type="checkbox"/> Hypertension (High BP) | <input type="checkbox"/> Preterm | <input type="checkbox"/> Ear Infection |
| <input type="checkbox"/> Cardiac Disorders | <input type="checkbox"/> Reproductive Disorders | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Throat Problems |
| | | <input type="checkbox"/> IV or Oral Bisphosphonates |

Other: _____

- | | | |
|---|--|--|
| <input type="checkbox"/> Past Smoker | <input type="checkbox"/> Alcohol Use | <input type="checkbox"/> Do you want help to quit? |
| <input type="checkbox"/> Current Smoker | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Wear Contacts/Glasses |

Family History	Relation	Description
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Neurological Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cardiac Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
GI Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Renal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
MS Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental Health Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol/Substance Use Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Other doctors I see: _____

Home Medical Supply: _____ Physical Therapy: _____

PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences
Please complete this assessment specific to the patient.

Patient Name: _____ Date of birth: _____ Date: _____

Address: _____

Housing & Income

1. What is your housing situation today?
 - I have housing
 - I do not have housing (staying with others, in a hotel, shelter, street, car, park, etc)
 - I choose not to answer

2. Are you worried about losing your housing?
 - Yes No
 - I choose not to answer

3. Household Size:
 - _____ Total Number of family members
 - I choose not to answer

4. Estimated annual household income
 - Income: \$ _____

Material Security

5. In the past year, have you or any family members you live with been **unable** to get any of the following when it was really needed?
 - Unable to get food
 - Yes No
 - I choose not to answer
 - Unable to get clothing
 - Yes No
 - I choose not to answer
 - Unable to get utilities
 - Yes No
 - I choose not to answer

6. Unable to get child care
 - Yes No
 - I choose not to answer

7. Unable to get medicine or any health care (medical, dental, mental health, vision)
 - Yes No
 - I choose not to answer

8. Unable to get phone service
 - Yes No
 - I choose not to answer

9. Unable to get housing or housing repair
 - Yes No
 - I choose not to answer

Insurance

10. What is your main insurance?
 - None/Uninsured Private insurance
 - CHIP Medicaid Medicaid
 - Other public insurance (CHIP) Medicare
 - Other public insurance (not CHIP)

Transportation/Isolation

11. Has lack of transportation kept you from appointments, meetings, work, or from daily living needs?
 - Yes, it has kept me from appointments/medications
 - Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
 - No lack of transportation
 - I choose not to answer

12. How often do you see or talk to people that you care about and feel close to?
 - Less than once a week
 - 1-2 times a week
 - 3-5 times a week
 - 5 or more times a week
 - I choose not to answer

Violence/Stress

13. Do you feel physically and emotionally safe where you currently live?
 - Yes No
 - I choose not to answer

14. In the past year, have you been afraid of your partner or ex-partner?
 - Yes No Unsure
 - I have not had a partner in the past year
 - I choose not to answer

15. How stressed are you?
 - Not at all Quite a bit
 - A little bit Very much
 - Somewhat I choose not to answer

Employment/Education

16. What is your current work situation?
- Unemployed
 - Part-time or temporary work
 - Full-time work
 - Otherwise unemployed, but not seeking work (student, retired, disabled, unpaid primary care giver)
 - I choose not to answer
17. What is the highest level of school that you have finished?
- Less than high school
 - More than high school
 - High school diploma/GED
 - I choose not to answer

Personal Characteristics

18. Which race(s) are you? Check all that apply.
- Asian Indian
 - Pacific Islander
 - White
 - Chinese
 - Korean
 - Other Asian
 - Other Pacific Islander
 - Filipino
 - I choose not to answer
 - Native Hawaiian
 - Black/African American
 - American Indian/Alaskan Native
 - Japanese
 - Vietnamese
 - Samoan
 - Guamanian or Chamorro
 - More than one race
 - Other
- If other, (please write): _____
19. What Ethnicity are you?
- Mexican, Mexican American or Chicano/a
 - Cuban
 - NOT Hispanic, Latino/a or Spanish Origin
 - Hispanic, Latino/a or Spanish Origin
 - Puerto Rican
 - I choose not to answer
20. What language are you most comfortable speaking?
- English
 - Other (please write): _____
 - Requires an Interpreter: _____
 - I choose not to answer

Situational Characteristics

21. Have you served in the United States military, armed forces or uniformed services?
- Yes
 - No
 - I choose not to answer
22. In the past year, have you spent more than 2 nights in a row in a jail, prison, or juvenile correction facility?
- Yes
 - No
 - I choose not to answer
23. At any point in the past 2 years, has season or migrant farm work been your or your family's main source of income?
- Yes
 - No
 - I choose not to answer

24. Are you a refugee?
- Yes
 - No
 - I choose not to answer

Community Services

25. Do you need assistance with any of the following?
- Renewal maintenance of MO Healthnet coverage/food stamps
- Yes
 - No
 - I choose not to answer

- Application assistance
(social service organizations, Medicaid, etc)
- Yes
 - No
 - I choose not to answer

- Budgeting/financial literacy
- Yes
 - No
 - I choose not to answer

- Health/disease education
- Yes
 - No
 - I choose not to answer

26. Are you currently a foster, kinship, or adoptive parent or child?
- Parent
 - Child
 - No
27. If yes, do you need any of the following?
- Foster child care/Respite care
- Yes
 - No
 - I choose not to answer

- Foster transition assistance/planning (change in placement, transitioning out of care, youth services and/or juvenile justice)
- Yes
 - No
 - I choose not to answer

28. Communication Issues?
- Hard of Hearing
 - Mute
 - Uses TTD Phone
 - Difficulty Reading
 - I choose not to answer
 - Legally Blind
 - Registered Service Animal
 - Prefers Forms/Read aloud
 - None of the above

29. Our health center offers a Sliding Fee Discount Program to help reduce the cost of care based on household income and size. Would you like to apply for this program today?
- Yes, I would like to apply
 - No, I decline at this time
 - Already Enrolled

30. Would you like an OCHC Community Health Worker (CHW) to help you with anything on this form?
- Yes
 - No