

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  |

**CHILD HEALTH HISTORY QUESTIONNAIRE**

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Has the child ever had any of the following conditions?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> ADD/ADHD               | <input type="checkbox"/> Chronic Ear Infections  | <input type="checkbox"/> Inguinal Hernia        |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Congenital Heart        | <input type="checkbox"/> Liver Disease          |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Congenital Anomaly      | <input type="checkbox"/> Migraine Headaches     |
| <input type="checkbox"/> Atopic Dermatitis      | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Mononucleosis          |
| <input type="checkbox"/> Behavior Problems      | <input type="checkbox"/> Down Syndrome           | <input type="checkbox"/> Obesity                |
| <input type="checkbox"/> Blood Disorders        | <input type="checkbox"/> Ear Tubes               | <input type="checkbox"/> Pneumonia              |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Premature Birth        |
| <input type="checkbox"/> Bronchiolitis          | <input type="checkbox"/> Gastroesophageal Reflux | <input type="checkbox"/> VP Shunt               |
| <input type="checkbox"/> Bulimia                | <input type="checkbox"/> Genetic Disorders       | <input type="checkbox"/> Renal Disease          |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> Seasonal Allergies     |
| <input type="checkbox"/> Cerebral Palsy         | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> Urological Problems    |
| <input type="checkbox"/> Chicken Pox            | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Anxiety                |
| <input type="checkbox"/> Wears glasses/contacts | <input type="checkbox"/> Hypertension            | <input type="checkbox"/> Depression             |
| <input type="checkbox"/> Smoking/Vaping         | <input type="checkbox"/> Alcohol/Substance Use   | <input type="checkbox"/> Mental Health Problems |

Other: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

Pharmacy of Choice: \_\_\_\_\_ City: \_\_\_\_\_

Are immunizations up to date? YES / NO Who does the child live with? \_\_\_\_\_

| 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 |          |             |
| Mental Health Problems          | <input type="checkbox"/> Yes <input type="checkbox"/> No |          |             |
| Alcohol/Substance Use Disorders | <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 |          |             |
| Other                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |          |             |

Surgeries: \_\_\_\_\_ Date \_\_\_\_\_

Life Events (Examples: Accidents, Stroke, Heart Attacks): \_\_\_\_\_ Date \_\_\_\_\_

I, the undersigned, do acknowledge I have completed this form honestly and to the best of my knowledge.

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**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