

Today's Date: \_\_\_\_\_

Primary Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Assigned Sex: \_\_\_\_\_ Gender Identity: \_\_\_\_\_

Primary language(s) spoken in home: \_\_\_\_\_

Briefly describe current difficulties: \_\_\_\_\_

\_\_\_\_\_

**Family Data**

Individuals in Home	Relationship	Age

**ADULTS**

Relationship Status:  Single  Common Law  Married  Separated  Divorced  Re-Married

**MINORS**

Custody Status\*:  Mother  Father  Other \_\_\_\_\_

*\*Provide copy of custody agreement as needed.*

**Family Data**

Name of Primary Care Clinic: \_\_\_\_\_

Name of Primary Care Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_

Is patient currently prescribed any medications?  No  Yes

1. Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Prescribed & monitored by: \_\_\_\_\_ When started: \_\_\_\_\_

For treatment of: \_\_\_\_\_

2. Name of medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Prescribed & monitored by: \_\_\_\_\_ When started: \_\_\_\_\_

For treatment of: \_\_\_\_\_

\_\_\_\_\_  
Signature of Individual Completing This Form

\_\_\_\_\_  
Relationship to Patient