Male-to-female/Transgender Female Other Deline to answer Other Don't know Deline to answer Asked but unknow Asked but unknow Mome phone: n/a Cell Phone: n/a Enter phone # below: Enter phone # below: Enter phone # below: Enter phone # below: Leave message? Y N Message? Y	Medicaid Number:Client Name:				Record Number: Date of Birth:				
Preferred Name: Previous First Name: Previous Last Name: Street address: County of Residence: City: State: Zip code: Mailing address: Do not mail City: State: Zip code: Date of Birth: Social Security: Birth Sex: Female Out of Birth: Social Security: Birth Sex: Female Other Birth: Social Security: Birth Sex: Female Other Birth: Social Security: Birth Sex: Female Other Birth: Social Security: Straight/Heterosexual Fereferred Pronout: Other Female Male Bisexual Fereferred Pronout: Other Gender queer Fereferred Pronout: Straight/Heterosexual Fereferred Pronout: Date of Birth: Social Security: Secondary Prono: Decline to answer Other Other Secondary Prono: Decline to answer Date of Birth: Social Security: Leave message? Name: Enter phone # below: Date of Birth: Secondary Phone: Decline to answer Date of Birth:	DAYMARK		Patient Information Sheet				Date Completed		
Street address: County of Residence: City: State: Zip code: Mailing address: Do not mail City: State: Zip code: Date of Birth: Social Security: Birth Sex: Female Male	Recovery Services			le:			Last Name:		
City: State: Zip code: Mailing address: Do not mail City: State: Zip code: Date of Birth: Social Security: Birth Sex: Female Male Outgreet of Birth: Social Security: Birth Sex: Female Preferred Pronoun: Outgreet of Birth: Social Security: Birth Sex: Preferred Pronoun: State: Outgreet of Birth: Gender Identity: State: State: They/then/theirs Image: Hale Gender: Gender/transgender Female They/then/theirs Image: Cell Phone: In/a Cell Phone: In/a Secondary Phone: Home phone: In/a Cell Phone: In/a Secondary Phone: Enter phone # below: Ente	Preferred Name:	Previous First Name:				Previous Last Name:			
Mailing address: Do not mail City: State: Zip code: Date of Birth: Social Security: Birth Sex: Female Male Current Gender: Female Female State; State// Hetrosexual Prefered Pronoun: Birth Sex: Female Male Straight/Hetrosexual Prefered Pronoun: Straight/Hetrosexual Dis/kr/hetrosexual	Street address:						County of Residen	ce:	
City:: State: Zip code: Date of Birth: Social Security: Birth Sex: Female Male Current Gender:	City:		State:				Zip code:		
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Current Gender: Gender Identity: Sexual Orientation: Preferred Pronoun: Male Male Straight/Heterosexual She/her/hers Male Male Bisexual She/her/hers Undifferentiated Male Bisexual They/them/theirs Genderqueer Other Choose not to disclose Don't know Home phone: n/a Cell Phone: n/a Day/Work Phone: n/a Enter phone # below: Enter phone # below: </td <td>City:</td> <td></td> <td colspan="3">State:</td> <td></td> <td colspan="2">Zip code:</td>	City:		State:				Zip code:		
Female Female Straight/Heterosexual She/her/hers Male Female-to-male/Transgender Male Lesbian, gay, or homosexual He/him/his Genderqueer Other Other Other Other Choose not to disclose Day/Work Phone:: n/a Enter phone # below: Cell Phone: n/a Alternate Phone # below: Enter phone # below: Leave message? Y N Leave message? Y N Preferred Contact Order: (Write 1, 2, 3, 4, or 5 next to each item to indicate which number to call first, second, third, etc) Enter phone Home Cell Day/Work Alternate Secondary Preferred Contact Order: (Write 1, 2, 3, 4, or 5 next to each item to indicate which number to call first, second, third, etc) Reave message? Mane:	Date of Birth:	Social Security:				Birth Sex: 🗌 Female 🗌 Male			
Home phone: n/a Cell Phone: n/a Day/Work Phone: n/a Alternate Phone: n/a Secondary Phone: Enter phone # below: Enter phone: Enter phone: Enter phone: Enter phone: Enter phone # below: Enter phone # below: </td <td>Female Male</td> <td colspan="3">hale le Jifferentiated Genderqueer Other Choose not to disclose</td> <td colspan="3"> Straight/Heterosexual Lesbian, gay, or homosexual Bisexual Other Choose not to disclose Don't know </td> <td>She/her/hers He/him/his They/them/theirs Ze/hir</td>	Female Male	hale le Jifferentiated Genderqueer Other Choose not to disclose			 Straight/Heterosexual Lesbian, gay, or homosexual Bisexual Other Choose not to disclose Don't know 			She/her/hers He/him/his They/them/theirs Ze/hir	
Enter phone # below: Iter phon				1		1			
Email address: n/a Preferred Contact Order: (Write 1, 2, 3, 4, or 5 next to each item to indicate which number to call first, second, third, etc) Home Cell Bay/Work Alternate Secondary EMERGENCY CONTACT INFORMATION LEGALLY RESPONSIBLE PERSON Name:	•						Secondary Phone: n/a Enter phone # below:		
Preferred Contact Order: (Write 1, 2, 3, 4, or 5 next to each item to indicate which number to call first, second, third, etc) Home Cell Day/Work Alternate Secondary EMERGENCY CONTACT INFORMATION Name:	Leave message? Y N Leave message? Y N Leave message?			Leave messa	age? 🗌 Y 🗌 N Leave message? 🗌 Y			Leave message? Y	
Home Cell Day/Work Alternate Secondary EMERGENCY CONTACT INFORMATION LEGALLY RESPONSIBLE PERSON Name: Relationship: Address: Address: City/State:Zip Code: Home Phone:Zip Code: Cell Phone: Work Phone:	Email address: 🔲 n/a								
EMERGENCY CONTACT INFORMATION LEGALLY RESPONSIBLE PERSON Name:							irst, second, third, e	tc)	
Name: Relationship: Address: City/State: Zip Code: City/State: Zip Code: Home Phone: Cell Phone: Cell Phone: Work Phone: Work Phone: Work Phone: Date of last visit with your Primary Care Practice:				-	,				
Relationship: Name: Address: Address: City/State: Zip Code: Tip Code: City/State: Phone: Zip Code: Cell Phone: Cell Phone: Work Phone: Work Phone: Primary Care Practice: Preferred Hospital: Date of last visit with your Primary Care Practice: Don't have a Primary Care Practice:					Self Parent Legal Guardian Other:				
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City/State: Zip Code: Home Phone: City/State: Cell Phone: Home Phone: Cell Phone: Cell Phone: Work Phone: Work Phone: Primary Care Practice: Primary Care Practice: Preferred Hospital: Date of last visit with your Primary Care Practice: Don't have a Primary Care Practice:									
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Primary Care Practice: Preferred Hospital: Date of last visit with your Primary Care Practice: Image: Care Practice									
Date of last visit with your Primary Care Practice: Don't have a Primary Care Pract									
							_		
Preferred Pharmacy Name: Pharmacy Address/Phone:	-	-					L] Don (ha	ve a Primary Care Practice	

Medicaid Number:					Record Number:				
Client Name:					Date of Birth:				
ETHNICITY (check one) Hispanic-Mexican American Hispanic-Puerto Rican Hispanic-Cuban Hispanic-Other Not Hispanic	RACE (check one) Black/African American White/Anglo/Caucasian Amer Indian/Native American Alaska Native Asian Pacific Islander Multiracial Other :			Ann Sin Ma Sep Div Wi	nulled	FUS (check one) er married) Partners	Primary Language (check one) English Sign Language French Spanish Other English Proficiency (Do you need an interpreter?) Yes No		
Employment Status (check one) Unemployed Employed Full time Employed Part Time Student Retired Homemaker Not available for work Armed Forces Seasonal/Migrant worker Employer: Occupation: Highest Grade Completed or GED or Degree:	Self-Help Programs (check one) How often have you attended a self-help program in the past 30 days? None in past month 1-3 times 4-7 times 8-15 times 16-30 times Some attendance, don't know number Number of Arrests in past 30 days (include arrest for any cause regardless of current status):				vate Res mer inde meless s rrection sidential ursing ho ster fam mily livi rsing ho ult care ult care mmunity mm. ICF	pendent housing shelter al facility Facility (excluding omes) ily/alternative ng	Referral Source (check one) Self/no referral Family/friends Other outpatient/ residential facility State facility Psychiatric service/ general hospital Non-residential treatment/ habilitation program Private Physician Nursing home Veteran's Administration Other health care Community Agency School Other:		
Family Size (number of people living in household, for whom you are financially responsible, including yourself):	Annual Family Income \$00			Are yo		ran?	Females Only: Currently Pregnant?		
		Insu	uranc	e Cover	age		I		
Medicaid		Yes]	No 🗌	No 🗍 ID Number:				
Medicare					ID Nu	Number:			
Blue Cross Blue Shield		Yes Yes			ID Number:				
			Yes N			umber:			
United Healthcare						imber:			
Humana		Yes	Yes N						
Cigna					ID Nu				
Aetna			No DID Number:		mber:				
The following questions are being asked to help identify if you need assistance for which a referral can be provided									
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?				Yes, current Yes, in past 12 m need/concern need/concern			onths but NOT current		
2. Within the past 12 months did the food you bought just not last and you didn't have money to get more?				Yes, current need/concern		Yes, in past 12 months but NOT current need/concern			
3. Do you have housing (a place to live)?			Yes						
4. Are you worried about losing your housing?			Yes, current need/concern			Yes, in past 12 months but NOT current need/concern			
CONTINUED ON NEXT PAGE									

Client Name:

Date of Birth:

5. Within the past 12 months, have you or your family members you live with been unable to get utilities (heat, electricity) when it was really needed?	No	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
6. Within the past 12 months, has lack of transportation kept you from medical appointments, getting your medicines, non-medical meetings or appointments, work, or from getting things that you need?	No	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
7. Do you feel physically and emotionally safe where you currently live?	No	Yes	
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by someone?	No	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
9. Within the past 12 months, have you been humiliated or emotionally abused in other ways by your partner or ex-partner?	No	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
10. In the past 12 months, have you had trouble affording health insurance (such as deductibles, copayments, etc.)	No	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
11. In the past 12 months, have you had trouble paying for or accessing medications?	No	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
12. In the past 12 months, have you had concerns over obtaining or maintaining employment?	No	Yes, current need/concern	Yes, in past 12 months but NOT current need/concern
Would you like to share anything additional relational relational relational relational relation and the second se	ted to yo	our needs or concerr	IS?

Adult Client-3 Month Update									
1. How would you rate your ability to deal with daily problems now?									
1 Much better	2 🗌 A little better	3 About the same	4 A little worse	5 🗌 Much worse	NA-New or Child client				
2. In general, how would	2. In general, how would you rate your overall health now?								
1 Excellent	2 Very good	3 Good	4 🔲 Fair	5 🔲 Poor	NA-New or Child client				
Parent/LRP with Child Client-3 Month Update									
1. How would you rate your child's ability to deal with daily problems now ?									
1 Much better	2 🗌 A little better	3 About the same	4 A little worse	5 🗌 Much worse	NA-New or Adult client				
2. In general, how would you rate your child's overall health now?									
1 Excellent	2 🗌 Very good	3 Good	4 🗌 Fair	5 🗌 Poor	NA-New or Adult client				

To the best of my knowledge, the questions on this form have been answered accurately. I understand it is my responsibility to inform DAYMARK, in writing, when I desire changes in this information, including the method of contacting me.

Completed by: _____

(If not client, list relationship)

_____ Date: _____