Basic Consumer Intake Form Updated June 3, 2021

Basic Client Information:		**Date of Assessment:**
*Last Name:	*First Name:	Middle Initial:
*Gender: ☐ Male ☐ Female ☐ Other: ☐	*Date of Birth:	*Age:
Residential Address:		
*Address Line 1:	*Address Line 2:	
*City:	*State:	*Zip:
*County:	Phone (Home):	
Phone (Mobile):	Phone (Work):	
Location Comments (Directions):		
Email Address:	Are you receiving Medicaid? ☐ Yes ☐ No	
What is your marital status? ☐ Married/Domestic Partner ☐ Single ☐ Widowed	Are you a veteran? ☐ Yes ☐ No	
*Lives: ☐ Alone ☐ With others	What is your primary language?	
*What is your race?	*Ethnicity? ☐ Hispanic/Latino ☐ Not Hispanic/Latino	
*Are you visually impaired (cannot be corrected with glasses)? ☐ Yes ☐ No		
How many people live in your household?	Is your monthly income below $1,073? ☐ Yes ☐ No	
Mailing Address, **if different** from physical Address:		
Address Line 1:	Address Line 2 (Apt #, Unit #, Floor #):	
City:	State:	Zip:
Are you interested in receiving nutrition counseling? ☐ Yes ☐ No		
Emergency contact name:	Relationship:	Phone Number:

I have been informed of the policies regarding voluntary contributions, complaint procedures and appeal rights. I am aware that in order to receive requested services, it may be necessary to share information with other departments or service provider and I herewith give my consent to do so. (If filled out by assessor or via phone, please have assessor check here and sign below ☐).

Signature _____ Date _____

Office use only - Information filled out by _____ Date _____