

**Mercy Family Health Center- Medical Safe Haven  
Patient Intake Form**

Client: \_\_\_\_\_ DOB: \_\_\_\_\_

Client Contact #: \_\_\_\_\_ Insurance: \_\_\_\_\_

Agency: \_\_\_\_\_ Date of referral: \_\_\_\_\_

Case Worker Name: \_\_\_\_\_ Contact #: \_\_\_\_\_

Date of Establishment: \_\_\_\_\_ via ( ) Court Order ( ) Voluntary Enrollment ( ) Other

**Social History**

- Primary Language: \_\_\_\_\_
- In the Foster System? (YES) (NO)
- City of Birth: \_\_\_\_\_
- Initial Age when exploited: \_\_\_\_\_

How many visits to the Emergency Department in the last 12 months? \_\_\_\_\_

- What hospital? \_\_\_\_\_

Goal for appointment (check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Establish Care | <input type="checkbox"/> Pregnancy             |
| <input type="checkbox"/> Mental health  | <input type="checkbox"/> Injury                |
| <input type="checkbox"/> STI screening  | <input type="checkbox"/> Substance/Alcohol use |
| <input type="checkbox"/> Medications    | Other: _____                                   |

List current medications:

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Client's primary mode of transportation to appointments?

Agency provided       Self       Does not have transportation

Does client have children who need care as well? (YES) (NO)

Does the patient know our clinic's particular involvement with your agency? (YES) (NO)

Will the caseworker be coming to the intake appointment with the client? (YES) (NO)

**Please fax back to 916-688-1012:**