**Client Intake Form**

Please complete **ALL** questions and return to UPBC Food Distribution Team at next distribution.

**Identification**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Name: \_\_\_\_\_\_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you the head of your household? (Circle one) Yes No

Address (street, apartment number, city, state, ZIP):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address (leave blank if same as Street Address):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In which county do you live? (Check one)

* Carter
* Unicoi
* Washington
* Other

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Income Sources**

|  |  |  |
| --- | --- | --- |
| **Type** | **Amount** | **Interval (monthly, yearly, etc.)** |
|  |  |  |
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**Demographics**

Gender (Check one)

* Female
* Male
* Transgender
* Do not identify as female, male, or transgender

Race/Ethnicity (Check all that apply)

* White
* Hispanic, Latino, or Spanish
* Black or African American
* Asian
* American Indian or Alaska Native
* Middle Eastern or North African
* Native Hawaiian or other Pacific Islander
* Other race or ethnicity

Education (Check one)

* Less than high school
* High school diploma/GED
* Some college
* Associate’s degree
* Bachelor’s degree
* Master’s degree
* Doctorate degree
* Vocational training

Employment (Check all that apply)

* Part-time
* Full-time
* Multiple jobs
* Unemployed & looking
* Unemployed & not looking
* Student
* Retired
* Unable to work

Marital Status (Check one)

* Single
* Married/domestic partnership
* Divorced
* Widowed
* Separated

Government Benefits Received (Check all that apply)

* Medicaid
* Medicare
* SNAP/food stamps
* Social Security
* Veterans Benefits
* WIC
* Families First
* LIHEAP
* SSI/SSDI/Disability
* Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Housing (Check one)

* House/apartment/condo
* Hotel/motel
* Shelter/mission
* Homeless
* At risk of becoming homeless
* Public housing
* Other (Please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you a veteran?

* Yes
* No

Are you disabled?

* Yes
* No

**Household Health**

Health conditions in your household (Check all that apply)

* Diabetes
* Heart disease
* High blood pressure
* Cancer
* Lung disease (COPD, emphysema, black lung)
* Asthma
* Prefer not to say

Does your household have health insurance?

* Yes
* No
* Prefer not to say

Does anyone in your household use tobacco, including e-cigarettes?

* Yes
* No
* Prefer not to say

Does anyone in your household use prescription drugs?

* Yes
* No
* Prefer not to say

Can your household members afford the prescriptions you need?

* Yes
* No
* Prefer not to say

Do your household members need to halve doses or use other methods to make your prescriptions last longer?

* Yes
* No
* Prefer not to say

Do your household members currently have a primary care provider?

* Yes
* No
* Prefer not to say

Has anyone in your household visited the following in the last 12 months? (Check all that apply)

* Primary care provider
* Urgent Care
* Emergency department
* Free clinic or site (RAM, Health Wagon, etc.)
* Prefer not to say

In the last 12 months, has anyone in your household been hospitalized?

* Yes
* No
* Prefer not to say

**Household Members**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Full Name** | **Date of Birth** | **Gender** | **Race or Ethnicity** | **Relationship to you** |
|  |  |  |  |  |
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