Admission Information for New Consumer

Full Name: *Last* *First* *Middle*		SS#: – –	Age:
Date of Birth:	If under age 18, parent/guardian: Any Custody/Guardian issues?		Sex at Birth: ❑Male or ❑Female
*Gender Identity: ❑M ❑F ❑Transgender Male ❑Transgender Female ❑Intersex ❑Nonbinary ❑Genderqueer ❑Questioning or Don't Know ❑Choose Not to Disclose			
Sexual Orientation: ❑Straight or Heterosexual ❑Lesbian or Gay ❑Bisexual ❑Queer or Pansexual ❑Questioning or Don't Know ❑Choose Not to Disclose			
Street Address:	City: County: State:		Zip:
Home Phone #:	Work Phone#:	Cell Phone #:	
Communication Preference: ❑Cell Phone ❑Home Phone ❑Work Phone ❑US Mail ❑Do Not Contact	Primary Language:		
Race: ❑Caucasian/White ❑African American ❑Native American ❑Asian ❑Hispanic ❑Bi-racial		Ethnic Origin:	
Marital Status: ❑Single ❑Married ❑Divorced ❑Widow ❑Co-habitating ❑Separated	Highest Level of Education: Years		
Employment Status: ❑Work Full-time ❑Work ❑Laid-Off ❑Student ❑Retired ❑Homemaker ❑Legally Disabled		Occupation:	
Housing: ❑Own/Buying ❑Rent ❑Live with Family ❑Live in Shelter ❑Other:		Number in house (household size):	

Do you smoke? ❑No ❑Yes If yes: ❑Current every day smoker ❑Current some day smoker ❑Current status unknown ❑Former smoker ❑Never smoked ❑Smoker ❑Unknown if ever smoked	Insurance Information: Medical Card ❑Yes ❑No Medicare? ❑Yes ❑No Private Insurance? ❑Yes ❑No Name of Insurance: _____
Any military Service: ❑No ❑Yes What branch of service?	Card holder's Name: _____ Card holder's date of birth:_____ Card holder's SS#: ___–____–____
Is your visit related to an automobile accident? ❑Yes ❑No	Is your visit related to a Worker's Compensation Issue? ❑Yes ❑No
Person to contact in case of emergency:	Relationship: Phone #:
Parent/Guardian Information: Name: _____ SS#: ___–____–____ Date of Birth: _____ Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____	Foster Parent Information: Name: _____ SS#: ___–____–____ Date of Birth: _____ Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Primary Care Provider(s) (outside providers):	Legal Status:
Have you ever received Pathways services before? ❑No ❑Yes If yes, What year:	What county:
Household income: $ ❑Monthly ❑Annually	Source of Income:
Who referred you to Pathways?	Pharmacy of Choice:
Allergies to medications:	Other allergies

Comments:

_____

_____

_____

_____

_____ _____

Staff Completing Form Date

* M – Male
F – Female
Transgender Male – designated female at birth but identifies as male
Transgender Female – designated male at birth but identifies as female
Intersex – at birth, had biological characteristics/reproductive organs associated with both male and female sex
Nonbinary or Genderqueer – identifies with or expresses a gender identity that is neither exclusively male nor female
Questioning or Don't Know – exploration by people who are unsure, still exploring, or concerned about applying a social label to themselves for various reasons