CLIENT DEMOGRAPHIC INFORMATION
FAMILY PLANNING

Client Name: ____ Birthdate: ________________
First *M.I.* *Last*

Preferred Name: ________________________________ Gender: ☐Female ☐ Male ☐Transgender

Address: ____

City: ______________________________________ State: ____________ Zip: ________________

Home Phone: ______________ Is it OK to call and leave a message for you at this number? ☐Yes ☐No

Cell Phone: ______________ Is it OK to call and leave a message for you at this number? ☐Yes ☐No

Is it OK to receive text messages at this number? ☐Yes ☐No

Cell phone carrier: _________________________

If no, how may we contact you? ____

Emergency Contact: ______________________ *Relationship:* __________ *Phone:* ____________
First *Last*

Marital Status:
- ☐ Married
- ☐ Divorced
- ☐ Single
- ☐ Widowed
- ☐ Separated

Ethnicity:
- ☐ Hispanic
- ☐ Non-Hispanic

Race:
(check all that apply)
- ☐ White
- ☐ Black/African American
- ☐ Am Indian/Alaska Native
- ☐ Asian
- ☐ Native Haw/Pac Islander

Primary Language:
- ☐ English
- ☐ Spanish
- ☐ Somali
- ☐ Russian
- ☐ Other: ________

Educational Status:
- ☐ Middle/High School *(Currently Enrolled)* *Grade:* _____
- ☐ No High School Diploma
- ☐ High School Graduate/GED
- ☐ Some College
- ☐ College Graduate

Financial Information: Number of people living in your household: ______________

List Working Family Members:	**Income**	*(Circle One)*
	$	Weekly Monthly
	$	Weekly Monthly

Sources of Income to Include:
Salary, Self-employed income, Student loans, Grants, Alimony, Child Support, Unemployment, Other income

Type of Medical Insurance? ☐ Medical Assistance ☐ MN Care ☐ Private Insurance ☐ Other ☐ None

MA ID#: ____________________

If you have a primary medical provider, please fill in the name below:

Primary Medical Provider: ________________________ Clinic: ____________________________

NAME	DOB	DATE	CHART #

Rev 4/2017