Intake Form

Please fill this form out completely and legibly.

Date of Birth / /	Last Name (as it appears on an ID)	First Name (matches ID)	MI
Preferred Name (or other names or aliases you use)		Social Security Number	
Email Address:		Gender ☐ Male ☐ Female ☐ Genderqueer ☐ MTF ☐ FTM ☐ Other _____	
Are you Hispanic? ☐ Yes ☐ No	What is your race? (Check all that apply to you) ☐ Black ☐ White ☐ Asian ☐ Native American or Alaskan Native ☐ Native Hawaiian or Pacific Islander ☐ Other: _____	Marital Status? ☐ Single ☐ Married ☐ Domestic Partnership ☐ Cohabitation ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown	What is your Citizenship? ☐ U.S. ☐ Legal Resident ☐ Other _____ ☐ Unknown

Street Address	City	State	ZIP
Mailing Address (leave blank if same as above)	City	State	ZIP

Living at Current Address Since: DATE / /	May we contact you by Mail? ☐ Yes ☐ No	Should mail be confidential? ☐ Yes ☐ No

Telephone (mark primary with *)	(If it is not OK to contact you, omit that number)
Home _____	Should the call be confidential? ☐ Yes ☐ No Are messages OK? ☐ Yes ☐ No
Work _____	Should the call be confidential? ☐ Yes ☐ No Are messages OK? ☐ Yes ☐ No
Mobile _____	Should the call be confidential? ☐ Yes ☐ No Are messages OK? ☐ Yes ☐ No
Other _____ (please note type, like message, TTY, etc…)	Should the call be confidential? ☐ Yes ☐ No Are messages OK? ☐ Yes ☐ No

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Emergency Contact Name	Telephone Number(s):	Relationship:	
Street Address	City	State	ZIP

Do you have special needs? Yes No

- ☐ Hearing
- ☐ Vision
- ☐ Reading difficulty
- ☐ Writing difficulty
- ☐ Wheelchair
- ☐ Speech
- ☐ Mobility
- ☐ ASL

What is your Primary Language?

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ German
- ☐ Chinese
- ☐ French
- ☐ Tagalog
- ☐ Korean
- ☐ Urdu
- ☐ Arabic
- ☐ Hindi
- ☐ ASL
- ☐ Other: _____

Who referred you to us?

- ☐ ASA (AIDS Services of Austin)
- ☐ Wright House Wellness Center
- ☐ Community Action
- ☐ David Powell Clinic
- ☐ Private Physician
- ☐ Friend
- ☐ CARE Program
- ☐ RBJ Health Center
- ☐ Other: _____

Educational Level Achieved:

- ☐ Graduate Degree
- ☐ Undergraduate Degree
- ☐ Some College
- ☐ Associate's Degree
- ☐ Technical School
- ☐ GED
- ☐ High School
- ☐ Partial High School
- ☐ Middle School
- ☐ Elementary School
- ☐ Not Yet School Age
- ☐ No School

Veteran?

- ☐ Yes
- ☐ No

If yes, what branch:

_____

Sexual Orientation

- ☐ Heterosexual
- ☐ Homosexual
- ☐ Bisexual
- ☐ Other: _____
- ☐ Decline to say

Transportation Access:

- ☐ Borrows vehicle
- ☐ Family/Friends
- ☐ None
- ☐ Owns Vehicle
- ☐ Public Transportation
- ☐ Special Transit
- ☐ Taxi
- ☐ Other: _____

Employment Status

- ☐ Full Time
- ☐ Part Time
- ☐ Not Employed
- ☐ Medically Unable
- ☐ Other (student/volunteer)

Income

Please indicate your total monthly income $_____

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Please fill this form out completely and legibly.

Do you have a primary care provider? ☐ Yes ☐ No If Yes, who is your provider? Doctor/Clinic Name _____ Doctor/Clinic Phone Number _____	Last HIV test Date: ___/___/_____ Results: _____ Last STI test Date: ___/___/_____ Results: _____	Do you have health insurance? ☐ Yes ☐ No Where do you want your PrEP medication delivered? ☐ The Kind Clinic ☐ Home Address ☐ Other: _____ _____ _____

I certify the information in this document is accurate to the best of my ability.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____