SACRAMENTO LIFE CENTER
Patient Intake – STD

Official Use Only Time Out ID Verification Done Pt. Name: ☐ Pt. DOB: ☐ Your Initials: ___________	Official Use Only Patient is at risk for falls YES ☐ Form completed NO ☐ Your Initials: _____	Official Use Only DVS YES ☐ NO ☐ Your Initials: ______

❑ Sacramento Clinic ❑ Mobile Clinic

Date of Visit:	Type of Visit: ❑ New ❑ Return	What is the primary reason for this visit? ❑ STD testing ❑ Other _______________

First Name:	Last Name:	MI:

Mailing Address:	City:	State:	Zip:

Phone:	May we leave a message? ❑ Yes ❑ No
Is it OK for us to contact you? (Check all that apply) ❑ By Phone ❑ By Mail ❑ By Email ❑ No	If ok to contact by email, please provide current email:

Date of Birth: Age:	Gender: ❑ Female ❑ Male ❑Male to Female Transgender ❑Female to Male Transgender	Race: ❑ African American ❑ Asian ❑ Caucasian ❑ East Indian ❑ Haitian ❑ Hispanic ❑ Native American ❑ Pacific Islander ❑ Other

Income: ❑ Employed ❑ Unemployed ❑ Dependent Source: ❑ Self ❑ TANF/SSI ❑ Parents	I live with: ❑ Alone ❑ Homeless ❑ Spouse ❑ Boy / Girl friend ❑ Parent(s) ❑ Other ______ ❑ Children ❑ Roommate ❑ Fiancé ❑ Shelter
Occupation or Job Title: Place of Employment: School Attending:	Marital Status: ❑ Single ❑ Engaged ❑ Married ❑ Live Together ❑ Separated ❑ Divorced
Student Status: ❑ Middle School or Jr. High ❑ High School ❑ College or University ❑ Not Student ❑ Trade School/Other	Would you like a referral to local organizations that can provide help with your spiritual needs? ❑ Yes ❑ No Religious Preference: ____

Have you ever been to Sacramento Life Center before? ❑ Yes ❑ No

❑ Same Name Other name? __________________________________

How did you hear about us?

____ ____/____/____
Patient Signature Date

____ ____/____/____
Reviewed By Sacramento Life Center Staff-Signature Date

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