N.E.W. Community Clinic

Patient Name: (print) _____
First (Full) Middle Last

Street Address: _____
Street Number Street Name Apt. No.

_____
City County State/Zip

Phone: _____ Date of Birth: _____ Age: _____ Social Security Number: _____

Gender: ☐ Male ☐ Female ☐ Decline to Answer ☐ Transgender (Male to Female) ☐ Transgender (Female to Male) ☐ Other

Sexual Orientation: ☐ Heterosexual/Straight ☐ Gay or Lesbian ☐ Bisexual ☐ Decline to answer ☐ Something else/other ☐ Don't know

Number of immediate family members, **including yourself**, whom you are financially responsible for: _____

Have you lived in a shelter, on the streets or been homeless in the last year? ☐ Yes ☐ No
Are you currently doubled up and would prefer to live on your own? ☐ Yes ☐ No
Do you have questions, or would you like to apply for Medicaid, Badger Care+, Marketplace or Food Share? ☐ Yes ☐ No

CURRENT HOUSING	
☐ Homeless Shelter	☐ Transitional
☐ Apartment	☐ House
☐ Street	☐ Housing Assistance / Title 8
☐ Doubling up	

INSURANCE	
☐ Medicaid	☐ Medicare
☐ VA Insurance	☐ None
☐ Private Insurance	

STATUS	
☐ Married	☐ Single
☐ Divorced	☐ Minor Child
☐ Separated	
☐ Widow/Widower	

RACE	NON-HISPANIC/ LATINO	HISPANIC/ LATINO
White	☐	☐
Black/African American	☐	☐
Asian	☐	☐
Pacific Island	☐	☐
Native Hawaiian	☐	☐
American Indian	☐	☐
More than one race	☐	☐
Other: _____	☐	☐
Refused to answer	☐	☐

EMPLOYMENT STATUS

☐ Full-Time	☐ Dependent
☐ Part-Time	☐ Seasonal/Temp
☐ Self-Employed	☐ Retired
☐ Unemployed	☐ Disabled
☐ Military Service / History of Military Service/Veteran	

LANGUAGE PREFERRED (please check one)

☐ English	☐ Spanish
☐ Hmong	☐ Other: _____

CURRENT INCOME STATUS (please [☒] Yes or No)

Do you or your family members receive the following? If YES, put in amount and check how often amount is received.

			Wage x Hours Or Gross Amount	Weekly	Biweekly	Monthly	Yearly
Payroll wages	☐ Yes	☐ No					
Self-employment income	☐ Yes	☐ No					
Aid for Dependent Children *(AFDC/W-2)*	☐ Yes	☐ No					
Supplemental Security Income *(SSI)*	☐ Yes	☐ No					
Social Security, Social Security disability	☐ Yes	☐ No					
Pension, retirement, disability income	☐ Yes	☐ No					
Unemployment compensation	☐ Yes	☐ No					
Alimony, child support	☐ Yes	☐ No					
Dividends and/or interest *(over $100 yr.)*	☐ Yes	☐ No					
Other:	☐ Yes	☐ No					

Ability to Pay: _____ Yearly Income: _____

CERTIFICATION STATEMENT:

I certify that the information provided is true and completed to the best of my knowledge. I hereby authorize release of any medical or financial information to (or by) the N.E.W. Community Clinic, Ltd. Necessary to verifying services and coordinating my care under its programs.

X_____
Authorizing Signature Date

N.E.W. Community Clinic

PATIENT HEALTH QUESTIONNAIRE

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(use "☒" to indicate your answer)	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
If your answers to the above two questions equals 3 or more, please continue answering all the questions below				
Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching TV	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
If you checked off any problem of this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				
Please [☒] one: ☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult**				

Score_____

CAGE QUESTIONNAIRE

Include alcohol use, illegal drug use and prescription drug use other than prescribed.	YES	NO
Have you ever felt you ought to cut down on your drinking or drug use?	☐	☐
Have people annoyed you by criticizing your drinking or drug use?	☐	☐
Have you ever felt badly or guilty about your drinking or drug use?	☐	☐
Have you ever had a drink or used drugs first thing in the morning to calm your nerves or to get rid of a hangover?	☐	☐

SOCIAL FUNCTIONING

	YES	NO
Living Arrangements	☐	☐
Lives with Spouse	☐	☐
Lives with Partner	☐	☐
Lives with Family	☐	☐
Lives Alone	☐	☐
Lives with Friends	☐	☐