PARISH NURSE INITIAL CONTACT FORM

Client Name ____ **Date of Initial Contact** _________________

Referred by: Self ____ **Clergy** ____ **Other Parishioner** ____ **MD** ____ **Hospital** ____ **Date of Birth** _________

SS # ___________________________ **Age** ________ **Gender: Male** _____ **Female** _____

Race: Caucasian _____ **African American** _____ **Other** _____ **Occupation** _______________________________

Health Care Plan/Provider: ___________________________ **Church Activity: Regular** ______ **Sporadic** ____
(Note any Secondary Insurance)

Employment Status: Employed _____ **Unemployed** _____ **Retired** _____ **Short-Term Disability** ______
Long-Term Disability _____ **Other** ____________________

Marital Status: Single _____ **Married** _____ **Divorced** _____ **Widowed** _____ **Separated** ___________

Client Address ____

Phone #: Home ______________________________ **Work** ________________________________

Advance Directives: Living Will _____ **DPOA** _____ **Primary MD** _________________________________
MD Phone # _________________________________

Emergency Contacts ____

Family Members (Living in Household)

Name	Relationship	Age	Pertinent Family History

Pharmacy ____________________________ **Phone** _________________________

Ability to Read: Yes _____ **No** _____ **Primary Language: English** _____ **Other** ______________

Risk Factors: Substance Use _____ **Overweight** _____ **Inactive** _____ **Family History** _____ **High Stress** _____

Spirituality Concerns ____

Community Agency(ies) Involved	Contact Person	Phone	Type of Service

Directions to Home ____

Comments ____