North Carolina Department of Health and Human Services

Division of Public Health – Reproductive Health Branch

**FAMILY PLANNING AND REPRODUCTIVE HEALTH**

**DEMOGRAPHIC INTAKE FORM**

Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Initial\_\_\_\_\_\_\_\_\_\_\_\_

Age \_\_\_\_\_\_ \*Date of Birth \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ month day year

Physical address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_ Mailing address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_ Phone (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (work) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County where you live \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Safe CONFIDENTIAL number we can call you with results?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Sex assigned at birth (check one)**  Male  Female

**\*How do you describe yourself? (check one)**

Male  Female  Female-to-Male/Transgender Male  Male-to-Female/Transgender Female

Genderqueer/neither Male nor Female/Non-binary  Other  Declined to Answer

**\*Race (check at least one)**  \***Ethnicity (check one)**

White  Hispanic  Not Hispanic

Black or African American \***Primary Language**

American Indian or Alaska Native  English  Spanish  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asian

Native Hawaiian or Other Pacific Islander

\*Monthly household gross income $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(include all sources of income)

\*Household size\_\_\_\_\_\_\_\_\_\_\_ (number of people living in household, including patient)

\*Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_