HMS
Health Management Services

"Guiding Minds, Nurturing Wellness"

Client Intake Form

This form gathers essential information to enroll you in the By Your Side Maternal Health Program. It ensures we can provide personalized, comprehensive care while complying with North Carolina state and HIPAA regulations.

Section 1: Personal Information

First Name:_____ Last Name:_____ Gender:_____

Marital Status:_____ Race/ Ethnicity:_____

Preferred Language:_____ Date of Birth:_____

Address:_____ State:_____ Zipcode:_____

Phone Number:_____Atl Phone Number:_____ Email:_____

Preferred Method of Communication:_____ Preferred Language:_____

Section 2: Insurance & Medicaid Information

Do you have Medicaid coverage? ___ Yes ___ No Medicaid ID Number: _____

If not, other insurance provider: _____Insurance ID Number: _____

Primary Care Physician: _____Physician's Phone: _____

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Section 3: Pregnancy Information

Expected Due Date: _____Number of Previous Pregnancies: _____

Current Trimester: ___ 1st ___ 2nd ___ 3rd Post___ Current Provider(OB/GYN): _____

Do you have a birth plan? ___ Yes ___ No If yes, please briefly describe:

_____

Have you previously experienced any pregnancy complications? ___ Yes ___ No

If yes, please describe: _____

Are you currently receiving prenatal care? ___ Yes ___ No (If no, would you like a referral to a provider? ___ Yes ___ No)

Do you have any current concerns or issues related to your pregnancy?
___ Yes (please describe): _____
___ No

Section 4: Medical History

Primary Care Provider (if different from OB/GYN): _____

Do you have any chronic medical conditions? ___ Yes ___ No If yes, please list: _____

_____

Are you currently taking any medications? ___ Yes ___ No If yes, please list: _____

_____

Allergies (food, medication, environmental): _____

Have you experienced any mental health concerns? ___ Yes ___ No If yes, please describe: ____

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Have you previously or currently been diagnosed with depression, anxiety, or any other mental health conditions? ___ Yes ___ No If yes, please specify: _____

Are you currently receiving mental health services?
___ Yes (provider name): _____
___ No (If no, would you like a referral to a mental health provider? ___ Yes ___ No)

Have you experienced any of the following during or prior to your pregnancy?

- Depression ___ Yes ___ No
- Anxiety ___ Yes ___ No
- Postpartum depression in a previous pregnancy ___ Yes ___ No
- Substance use (past or current) ___ Yes ___ No

Would you like to discuss any mental or emotional concerns with our peer support specialists?
___ Yes ___ No

Do you smoke? ___ Yes ___ No

Do you use tobacco? __ Yes __No

Do you consume alcohol? ___ Yes ___ No

Do you use any recreational drugs? ___ Yes ___ No If yes, please list: _____

Section 5: Social and Economic Information

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Other

Living Situation:
___ Stable Housing
___ Temporary Housing
___ Unstable Housing

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Do you have reliable transportation?
___ Yes ___ No

Do you have any type of food insecurity?

___ Yes ___ No

Do you have access to utilities? (water, electricity, etc.):

___ Yes ___ No

Do you have access to child care?:

___ Yes ___ No

Employment Status:
___ Employed (full-time/part-time)
___ Unemployed
___ Student

Domestic violence or unsafe living conditions?

___ Yes ___ No

Financial difficulties?

___ Yes ___ No

Do you engage in any form of physical activity?

___ Yes ___ No

Are you following a specific diet currently?

___ Yes ___ No

Household Income:
___ Less than $20,000/year
___ $20,001-$40,000/year
___ $40,001-$60,000/year
___ Over $60,000/year

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Section 6: Consent to participate and Release of Information

By signing below, I consent to participate in the By Your Side Maternal Health Program, and I understand that:

- Privacy and Confidentiality: My information will be kept confidential and shared only with authorized healthcare providers and agencies to coordinate my care in compliance with HIPAA and North Carolina regulations.
- Data Collection: I consent to the collection of my health and personal data for the purposes of improving maternal and infant health outcomes. My information will be stored securely and used in aggregate for research and program evaluation.

- Referral Services: I authorize the program to refer me to community services, healthcare providers, or other agencies as necessary to support my well-being during pregnancy and postpartum.
- Voluntary Participation: I understand that participation is voluntary and that I may withdraw from the program at any time.

I have reviewed the information provided, and I understand my rights and responsibilities as a participant in the program.

Section 7: Signature and Consent

Client Signature:
Date:

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Witness Signature:
Date:

For Office Use Only

Reviewed by:
Date: