	Subject: SGPPP Client Intake *COA:* Applies to: St. Gabriel's Pregnancy and Parenting Program	**Client Intake Form** Form: 1500-01 Effective: 10/19/2020 Revised: 10/22/2020

Catholic Charities Staff Only

Date: _____ CCCTX Employee: _____

GPL: _____ e-Kyros: _____

Intake Start Time: _____ End Time: _____

Client Information

First Name:	Last Name:	Sex (M/F):
Are you a United States Citizen, a United States national, or an alien who qualifies under 1 Texas Administrative Code Section 366? (i.e. do you have the citizenship status required to receive Medicaid in the State of Texas?) *Note: your answer to this question is confidential and will have no impact on whether you receive program services* ❑ Yes ❑ No		
Are you or your partner: Pregnant: ❑ Yes ❑ No A parent of (a) child(ren) under 3 years old: ❑ Yes ❑ No	If you or your partner are currently pregnant: Due date: Estimate number of weeks since start of last normal menstrual cycle (baby's gestational age): What was the earliest trimester that prenatal care was received from a medical professional?	
Date of Birth:	Cell Phone:	Email:
Please mark the following ways we may contact you: **Please note we use an automated service to send reminders via text message:** ❑ Email ❑ Mail ❑ Phone ❑ Text ❑ Do not Contact		Country of Origin:
Address:		
City:	State:	Zip/Postal:
Texas County of Residence:	Primary Language/Language of Preference:	
Highest Level of Education:		

Race/Ethnicity

❑ Anglo ❑ Asian ❑ African American ❑ Am. Indian/Alaska Native ❑ Hispanic (any race)

❑ Hawaiian/Pacific Islander ❑ Native American ❑ Unknown ❑ Other: _____

Household Information

How many individuals live in your household? _____

Please list all household members and relations: **(Start with Baby being enrolled)**

First Name	Last Name	Relationship	Sex (M/F)	Date of Birth	Weight at Birth (lb/oz) (children only)

Employment

Are you currently employed? ❑ Yes ❑ No

If yes, Employer: _____ Address: _____

May we call you at work? ❑ Yes ❑ No Work Phone: _____

Do you have experience with the United States Military? ❑ Yes ❑ No

If yes, please check the boxes which apply:
❑ Active Duty ❑ Veteran ❑ Reserve ❑ National Guard ❑ Dependent ❑ Widow/Widower

Income

Estimated *Monthly* Household Income: _____

Please check any current sources of income/support:
❑ Wages ❑ Pension ❑ Food Stamp ❑ Child Support ❑ Social Security ❑ SSI/SSDI
❑ Unemployment Ins. ❑ Veteran's Benefits ❑ Retirement ❑ TANF
❑ Workers Compensation ❑ Other: _____

Visit Information

How did you hear about us?

❑ Priest/Church/GA ❑ Friend/Relative ❑ School ❑ Previous/Current Client ❑ Internet ❑ Community Organization
❑ Doctor/Hospital: _____ ❑ 800#/Hotline ❑ CCC TX Program _____ ❑ Other _____

Have you ever been to our pregnancy center before? ❑ No ❑ Yes
If Yes, Date: _____ If under a different name, please state here: _____

What is the primary reason for your visit?
❑ Case Management ❑ External Referrals ❑ New Pregnancy ❑ Post-Abortion Help ❑ Pregnancy Classes ❑ Parenting Classes ❑ Life Skills Classes ❑ Infant/Toddler Needs (Formula, Diapers, etc.)