

Date: _____ **Time:** _____

Client/Family Name: _____

DOB: _____ Age/Age Range: _____ Gender: M F Marital Status: _____

Address: _____

Phone: **H:** _____ **W:** _____ **Other:** _____

Name:	Family/Significant Others:	Relationship:	Address:	Phone:
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*Indicates emergency contact

Client Congregational Status (Circle): Member Non-member

Advanced Directives: Y N **Durable Power of Attorney for Health Care:** Y N

Funeral Planning: Y N Agent Name: _____ Phone: _____

Primary Health Care Physician Name: _____ Phone: _____

Other Health Care Professional Name: _____ Phone: _____

Purpose of Contact: Spiritual____ Psychosocial____ Cancer____ Endocrine____

Cardiovascular____ Chronic Disease__ GU/Reproductive_____

Infectious Disease____ Mental Health____ Musculoskeletal____ Neurological____

Pulmonary____ Sensory____ Health-seeking behavior____

Safety/Environment____ Financial____ Other {specify} _____

Additional Information: _____

Parish Nurse Signature: _____

Congregation _____

