The Steven A. Cohen Military Family Clinic
at the University of Pennsylvania

Personal Information

Full Name: _____ **Birth Date:** _____
Last *First* *M.I.* *mm/dd/yyyy*

Pronouns: Select one Other pronouns: _____

Gender: Select one My gender isn't listed (please describe): _____

		Ok to leave message?	Text Reminders?	Mobile Provider / Network
Mobile Phone:	_____	◯ Yes ◯ No	◯ Yes ◯ No	_____
Day Phone:	_____	◯ Yes ◯ No		
Evening Phone:	_____	◯ Yes ◯ No		

		Ok to email?
Email Address:	_____	◯ Yes ◯ No

My preferred contact method is: Email

Your insurance will NOT be billed for today's visit. The following questions are for informational purposes only.

Do you currently have health insurance? ◯ Yes ◯ No *If yes, what type?* _____

In the future, if there was an option to have treatment billed to your insurance, would you consider this option? ◯ Yes ◯ No

Emergency Contact Information

Full Name: _____ **Relationship:** _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP*

Mobile Phone: _____ **Ok to leave message?** ◯ Yes ◯ No

Day Phone: _____ **Ok to leave message?** ◯ Yes ◯ No

Military Background – Patient (You)

Did you serve in the U.S. military? ◯ Yes ◯ No

Military Branch: _____ **National Guard:** Select one **Reserves:** Select one

Military Rank: _____ **MOS:** _____

Military Service Dates: _____

Military Discharge Status: Select one **Are you VA-eligible?** Select one

Are you currently enrolled in the VA for healthcare? Select one

If YES, what type of service are you currently receiving from the VA? Check all that apply:

- ☐ Primary health care
- ☐ Prescription medication
- ☐ Mental health evaluation
- ☐ HUD/VASH
- ☐ Mental health treatment
- ☐ Specialty care: _____
- ☐ Other: _____

Are you VA service connected and/or applying for service connection? Check all that apply:

☐ Connected ☐ Applying ☐ Neither ☐ Don't know

For what? _____ *Rating:* _____

Military Background – Your Family Member(s)

Did an immediate family member serve in the U.S. military? ◯ Yes ◯ No **Relationship:**

Their Branch: _____ **National Guard:** Select one **Reserves:** Select one

Their Rank: _____ **Their MOS:** _____ **Service Dates:** _____

Military Discharge Status: Select one **Is the veteran VA-eligible?** Select one

Is the veteran currently enrolled in the VA for healthcare? Not applicable

Is the veteran VA service connected? Not applicable

For what? _____ *Rating:* _____

Are you a caregiver for a veteran/family member? Select one

Caregivers – both formal/paid and informal/unpaid – provide routine support, such as scheduling medical appointments, help with medication management, emotional support, personal care, and more. If you are unsure, select "I'm not sure."

Personal Background Information

Sexual orientation: Prefer not to say My orientation isn't listed (please specify): _____

Marital Status: (Select all that apply)

☐ Now married ☐ Divorced ☐ Separated ☐ Widowed ☐ Never married
☐ Living with partner ☐ Other: _____

Race/Ethnicity: (Select all that apply)

☐ American Indian/Alaska Native ☐ Asian/South Asian ☐ Black/African American
☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White (non-Hispanic)
☐ I prefer to self-describe (please specify): _____

Highest level of education completed: Select one **Current employment status:** Select one

What is your annual household income? $ _____

How much of your annual household income comes from wages? $ _____

How much of your annual household income comes from subsidies (e.g., disability benefits/ social security/ TANF/ other support)? $ _____

Please select which subsidies: Select one Other: _____

Who currently resides in your home?

Name	Age	Relationship to Patient

Are there any firearms in your home? Select one

If yes, how are they stored? _____

_____

Mental Health History

Have you ever received counseling, psychological, or psychiatric treatment? ◯ Yes ◯ No

Type of Problem	Treatment Type	Treatment Duration	Where did you receive treatment?
	Select one		
	Select one		
	Select one		
	Select one		

Were you satisfied with you treatment? ◯ Yes ◯ No

Are you currently receiving counseling, psychological, or psychiatric treatment? ◯ Yes ◯ No

If yes, please explain: _____

Is there any family history of mental health concerns (e.g., depression)? ◯ Yes ◯ No

If yes, please explain: _____

Medical History

Name and contact info of primary physician: _____
Name *Phone*

Date of last physical exam: _____
mm/dd/yyyy

Name and contact info of other medical providers: _____

Do you have any chronic illnesses or current physical problems? ◯ Yes ◯ No

Do you smoke? ◯ Yes ◯ No

Is there any family history of significant medical problems? ◯ Yes ◯ No

Are you taking any prescription or non-prescription medications? ◯ Yes ◯ No

If yes: Type of medication Dose size Dose frequency

In the past 2 weeks, were there any changes in medication? ◯ Yes ◯ No

If YES, what were the changes? _____

How often do you miss a dose of your medications? _____

Have you noticed any side effects of your medications? _____

Do you have an advance directive? Select one

If YES:

Name: _____ Phone: _____

To learn more about advance directives, visit www.ourcarewishes.org.