

DS RIP Participant Intake Form

PARTICIPANT INFORMATION

Parent/Guardian Name (First, Middle Initial, Last)	Today's date Location
Street address, city, ZIP code	Date of Birth (XX-XX-XXXX)
Primary phone number Mobile phone number	Male Female
Household income (Annual)	Gender (Circle One)
African-American Caucasian Asian-American Latin-American	Hispanic Non-Hispanic
Race (Circle One)	Email address
Preferred language	# of People in Household
Do you have health insurance?	Ethnicity (Circle One)
<input type="checkbox"/> YES <input type="checkbox"/> NO	Marital status
If YES, who is your insurance provider? _____	
Do you have any of the following?	
<input type="checkbox"/> Medicaid <input type="checkbox"/> CHIP <input type="checkbox"/> Medicare <input type="checkbox"/> TANF <input type="checkbox"/> N/A	
Are you interested in the following HCPH programs? (Check all that apply)	
<input type="checkbox"/> Healthy Lifestyle <input type="checkbox"/> Expanded Mobile Health Clinics <input type="checkbox"/> N/A <input type="checkbox"/> Youth Dental <input type="checkbox"/> Tobacco Cessation	
How would you like to be contacted? (Check all that apply):	
<input type="checkbox"/> By Phone <input type="checkbox"/> By Mail <input type="checkbox"/> By Email: _____	
Which social media platforms do you use? (Check all that apply)	
<input type="checkbox"/> Twitter <input type="checkbox"/> Facebook <input type="checkbox"/> Pinterest <input type="checkbox"/> Instagram <input type="checkbox"/> Tumblr	
How did you hear about us? (Check all that apply)	
<input type="checkbox"/> Referral <input type="checkbox"/> Community Event <input type="checkbox"/> Social Media <input type="checkbox"/> Flyer <input type="checkbox"/> Community Health Worker <input type="checkbox"/> Other: _____	

CONTINUE TO NEXT PAGE



Child's Name (First, Middle Initial, Last)

Child's Date of Birth (XX-XX-XXXX)

Male | Female

Child's Gender (Circle One)

Does this child have health insurance?

YES

NO

If YES, who is your insurance provider? _____

Does this child have any of the following?

Medicaid CHIP STAR STAR Health N/A

Has this child seen a Primary Care Physician (PCP), OB/GYN, or Nurse Practitioner (NP) between the months of October 2014-September 2015?

YES

NO

If YES, did he/she receive any of the following?

BMI percentile documentation

Nutrition Counseling

Physical Activity Counseling

Has this child seen a PCP, OB/GYN, or NP for a routine health exam between the months of October 2013 – September 2015?

YES

NO

For Administrative Use Only:

Child's Initial Height (in.): _____

Child's Initial Weight (lbs.): _____

Initial BMI: _____

Child's Final Height (in.): _____

Child's Final Weight (lbs.): _____

Final BMI: _____

The privileged and confidential medical information in this demographic form is intended only for the individual designated above. This information is deemed Protected Health Information (PHI) and is protected by the Texas Health and Safety code and HIPAA regulations. Others are hereby notified that disclosure, copying, distribution, or taking action based on the content of this information is strictly prohibited. If you receive this demographic form in error, please notify HCPH immediately at 713-439-6000.

Signature grants permission to Harris County Public Health, its employees or representatives to take and use photographs, videotape, and digital images of me and/or my child/ren for use in promotional or educational materials. The materials might include printed or electronic publications, web sites or other electronic communications. I further agree that my name and identity may be revealed in descriptive text or commentary in connection with the images. I authorize the use of these images indefinitely without compensation to me. All materials shall be the property of HCPH.

X

(Parent/Guardian) Signature

Date

For Administrative Use Only:

Input Initial | Input Date