

Client Identification

Program #

ID #

Enrollment Date (mm/dd/yyyy)

Last Name

First Name

Middle Initial

Address

City

State

Zip Code

County of Residence

(001 – 099, or 111 for outside Iowa)

Phone

(XXX) XXX-XXXX

Email



Complete this form
once per year at
annual enrollment.
Please PRINT all
information.

What is the primary language spoken in your home:

- | | | |
|------------|----------------|----------------|
| 1. English | 7. Japanese | 13. Creole |
| 2. Spanish | 8. Korean | 14. Portuguese |
| 3. Arabic | 9. Polish | 15. Hmong |
| 4. Chinese | 10. Russian | 16. Other |
| 5. French | 11. Tagalog | |
| 6. Italian | 12. Vietnamese | |

Do you want to receive written health information in:

1. English
2. Spanish
3. Vietnamese
4. Other

Gender Identity (mark only one option):

1. Female
2. Trans Man
3. Trans Woman
4. Other
5. Don't Know
6. Refused

Sexual Orientation (mark only one option):

1. Straight or Heterosexual
2. Lesbian
3. Gay
4. Bisexual
5. Other
6. Don't Know
7. Refused

Client Demographic Information

1. First time ever enrolled in the Iowa Care for Yourself program?

1. Yes
2. No (*continue with questions 2-5*)

1a. Birth Date *(mm/dd/yyyy)*

1b. Maiden Name

1c. Hispanic or Latina Origin?

1. Yes
2. No
3. Unknown

Please answer 1d-1i to identify your race

Yes No Unknown

1d. White

1e. Black or African American

1f. Asian

1g. Native Hawaiian or Pacific Islander

1h. American Indian or Alaska Native

1i. Some other race

(Continue with questions 2-5)

2. Health Insurance (*mark only one option*)

1. None
 - 1a. Date referred to insurance *(mm/dd/yyyy)*

2. Insurance (*Includes Medicare Part B*)

3. Medicare A (*not Part B*)

4. Under-insured (*Assistance with co-pay and/or high deductible*)

3. Monthly Income \$

4. Family Unit Size

5. Education (check highest level attained)

1. Less than 9th grade
2. Some high school
3. High school graduate or equivalent
4. Some college or higher
5. Don't know/Not sure

Client Medical History

6. Have you had breast cancer?

1. Yes
2. No
3. Don't know/Not sure

7. Has your mother, grandmother, aunt, sister, or daughter had breast cancer?

1. Yes
2. No
3. Don't know/Not sure

8. Have you had a hysterectomy?

1. Yes

8a. Due to cervical cancer?

1. Yes

2. No

3. Unknown

8b. Cervix present?

1. Yes

2. No

3. Unknown

2. No

3. Don't know/Not sure

Client Smoking History

9. Smoking History (*mark only one option*):

1. Current Smoker

2. Quit (1-12 months ago)

3. Quit (More than 12 months ago)

4. Never Smoked

10. About how many hours a day, on average, are you in the same room or vehicle with another person who is smoking?

Hours

Less than one

None

To be completed by Program Coordinator: (for 1-3 check all that apply)

11. Client:

1. Fax referral to a proactive Quitline (check only one of a or b)

a. Signed by participant

b. Verbal confirmation provided

2. Referred to a local community-based cessation program

3. Provided Quitline contact information

4. Not referred to Quitline or community cessation program or provided Quitline contact information

5. Refused any referral or information