

Client Identification



Program # _____

ID # _____

Enrollment Date ____/____/____ (mm / dd / yyyy)

Last Name _____

First Name _____ Middle Initial _____

Address _____

City _____

State ____ Zip ____ County of Residence ____ (001-099, or 111 for outside Iowa)

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

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)

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)

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

1b. Maiden Name _____

1c. Hispanic or Latino Origin?

- 1. Yes
- 2. No
- 3. Unknown

Please answer 1d-1i to identify your race

Yes	No	Unknown	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1d. White
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1e. Black or African American
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1f. Asian
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1g. Native Hawaiian or Other Pacific Islander
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1h. American Indian or Alaska Native
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1i. Some other race

(Continue with questions 2-5)

- 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

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

8a. Due to cervical cancer? →	<input type="radio"/> 1. Yes <input type="radio"/> 2. No <input type="radio"/> 3. Don't know/Not sure
8b. Cervix present? →	<input type="radio"/> 1. Yes <input type="radio"/> 2. No <input type="radio"/> 3. Don't know/Not sure

Client Smoking History

9. Do you now smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)

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 Coord.: (for 1-3, check all that apply)

11. Client:
- | |
|---|
| 1. Fax referral to a proactive Quitline (check only one of a or b): |
| <input type="radio"/> a. Signed by participant |
| <input type="radio"/> 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

