



Client Services Screening Form

CLIENT INFORMATION

Client's Full Name: _____ DOB: _____ Race: _____

Significant Other's Name: _____ DOB: _____ Race: _____

Please Circle: Single Married In a Relationship

Client's Address: _____ Phone Number: _____

City: _____ State: _____ Zip Code: _____ County: _____

Email Address: _____

Child(ren) Name(s) & DOB: _____

Are you expecting? Yes____ No____ If Yes, What is your expected Due Date: _____

Prenatal care started at _____ weeks.

PROGRAM SERVICES

The Platte County Health Department offers a variety of wonderful services for you and your family. Services offered include **FREE** programs with a family support worker who provides you with support, education, and community referrals based on the needs of your family. Topics covered may include child development, breastfeeding, newborn care, labor and childbirth, family healthcare, parenting skills, stress reduction and strengthening relationships. A representative from the Platte County Health Department will be calling you to provide you with more information.

I hereby give my permission to share this information with the Platte County Health Department and Healthy Families Counseling and Support to follow up with the information provided.

Client Signature

Date

FOR OFFICE USE ONLY

Staff reviewing form: _____

Date received: _____ Date faxed: _____

DOC: _____ DOV: _____ REFERRED: _____

Additional Concerns/Comments: