Non-Cash Benefits received from any source in the past 30 days? ❑ Y ❑ N ❑ Don't know ❑ Refused to answer

Source of Monthly Non-Cash Benefits: Check as many as needed

❑ Food Stamps/SNAPS (Estampillas) $_____
❑ Medi-CARE
❑ WIC
❑ CalWORKs Childcare Services
❑ Other CalWORKs Services
❑ Other source: _____
❑ None (Nada)
❑ Medi-CAL
❑ State Children's Health Insurance
❑ Veteran's (VA) Medical Services
❑ CalWORKs Transportation Services
❑ Section 8, public housing, or other ongoing rental assistance
❑ Temporary Rental Assistance

Total Monthly Income from all sources (Ingreso Mensual total) **$_____/per month (Mensual)**

Occupation (Profesion):

Client Education (Educación)

❑ High School Graduate (Graduado de Secundaria)
❑ ____th Grade (Grado) ❑ No School (No Escuela)
❑ Some College/Vocational (Entrenamiento vocasional)
❑ College Graduate (Graduado de Colegio) ❑ Other (Otro) _____

Marital Status: (Estado Marital)
❑ Single (Soletero)
❑ Married (Casado)
❑ Divorced (Divorciado)
❑ Other (Otro):_____

Is client living with Batterer? (Esta viviendo con el agresor?)
❑ **Y** (Si)
❑ **N** (No)

Is client Head of Household?
❑ **Y** (Si)
❑ **N** (No)
If not, client is:
❑ Spouse
❑ Partner
❑ Child
❑ Step-Child
❑ Other:_____

Batterer is current or former (Agresor es o era):
❑ Boyfriend ❑ Husband
❑ Girlfriend ❑ Wife
❑ Other:_____

Victim's Sexual Orientation
❑ Hetrosexual ❑ Lesbian
❑ Gay ❑ Bisexual
❑ Other_____
❑ Decline to answer

Length of relationship (Tiempo en la relación):

Does client have a primary physician or health clinic for medical care?
❑ Y (Si)❑ N (No)

Name of doctor:_____
Phone #:_____

Name of pediatrician:_____
Phone #:_____

Physical Disability?
❑ No ❑ Yes ❑ Don't Know ❑ Refused to Answer
IF YES
Currently Receiving Services for This?
❑ No ❑ Yes ❑ Don't Know ❑ Refused to Answer

Developmental Disability?
❑ No ❑ Yes ❑ Don't Know ❑ Refused to Answer
IF YES
Currently Receiving Services for This?
❑ No ❑ Yes ❑ Don't Know ❑ Refused to Answer

Is Client Pregnant? (Cliente esta embarazada?)
❑ Y (Si) ❑ N (No)

Is Client a Veteran?
❑ Y ❑ N ❑ Don't know ❑ Refused to answer

Mental Health Issues?
❑ No ❑ Yes ❑ Don't Know ❑ Refused to Answer

IF YES
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?
❑ No ❑ Yes ❑ Don't Know ❑ Refused to Answer

Currently Receiving Services for This?
❑ No ❑ Yes ❑ Don't Know ❑ Refused to Answer

Type of Medical Insurance (Tipo de Aseguranza Medica):
❑Medi-Cal ❑ Emergency Medi-Cal ❑Healthy Families ❑ Kaiser Kids ❑Private Insurance ❑AIM ❑California Kids ❑None Notes:_____

Health/ Medication

Chronic Health Condition?
❑ No ❑ Yes ❑ Don't Know ❑ Refused to Answer
IF YES
Currently Receiving Services for This?
❑ No ❑ Yes ❑ Don't Know ❑ Refused to Answer

HIV/Aids ?
❑ No ❑ Yes ❑ Don't Know ❑ Refused to Answer
IF YES
Currently Receiving Services for This?
❑ No ❑ Yes ❑ Don't Know ❑ Refused to Answer

Is client taking any medication? (esta tomando medicina?)
❑ Yes, for physical needs
❑ Yes, for emotional needs ❑ No

Required medication:

Is medication life sustaining? ❑ Y ❑ N

Reproductive Health:

Using birth control? ❑ Y ❑ N If yes, which method: _____
1st day of last menstrual cycle (period): _____
Have you had unprotected intercourse in the past 5 days? ❑ Y ❑ N If yes, when? _____ Would you want to get pregnant? ❑ Y ❑ N
If no, refer for emergency contraception

Do you exercise? (hace ejercicio?) ❑ Y (Si) ❑ N (No) **If so, how many times per week?** (cuantes veces a la semana?)