Parish Nursing Services
Client Interaction Form

Client Name:________________________________________________________________________
DOB:______________  Age/Age Range ________________ Date: ________________
Gender M F  Marital Status ___________________ Time:___________________
Address: ________________________________________________________________
Phone: _________________________________________________________________

Ethnic Heritage1(circle): C A H OA NA ME FE MC U O
Congregational Status (circle): Parishioner Non-Parishioner
Referral Source2(circle): S P NP PS MD HCP M O PN FAM
Contact Person: _________________________ Phone: ___________________________
Advanced Directives: Y N Living Will Y N Durable Power of Attorney for Health Care Y N
Primary Health Care Professional: ___________________________________________
Address: ___________________________________ Phone: _______________________

Pertinent Medical History:(circle) DM HTN Cardio Vascular Pulmonary
Cancer Glaucoma Urinary Other: _____________________________________________
Pertinent Medication History: _______________________________________________

Comments/Additional Information: ___________________________________________

☐ Has BP screening form  Parish Nurse X_________________________
Congregation_________________________________________

1 C=Caucasian; A=African American/Black; H=Hispanic; OA=Oriental/Asian; NA=Native American;
ME=Middle Eastern; FE=Far Eastern; MC=Multi-Cultural; U=Unknown; O=Other
2 S=Self; P=Parishioner; NP=Non-Parishioner; PS=Pastoral Staff; MD=Physician; HCP=Other Health Care
Professional; M=Media; O=Other; PN=Parish Nurse; FAM=Family