Fax Information to:
Attention:

CONFIDENTIAL

INTAKE FORM

Date: ______________________

Name: ______________________
(First, Middle Initial, Last)

Current Address: ______________________

City/Island: ____________ / ____________ Zip Code: ________ Phone No.:______________

Presenting Problem(s): ______________________

____

____

Other Reference No. (A#, Adolescent Judiciary #, etc.): ____________ Citizenship: ____________

Date of Birth: ______________ Birth Place: ______________

Biological Gender: ______________ Gender Identity: ______________

Race: ______________ Ethnicity: ______________

Initial Contact: ______________________

Source of Referral: ______________________

Do you consent for (AGENCY NAME:____________) to contact the Source of Referral? ☐ Yes ☐ No

Referral Contact Name: ______________ Phone No: ______________

Personal Contact Name: ______________ Phone No: ______________

Emergency Contact Name: ______________ Phone No: ______________
(By entering contact information, you are consenting that we contact this person in case of emergency)

Health Insurance: ______________ Membership #: ______________

Employment Status: ______________ Veteran: ☐ Yes ☐ No

Current living arrangements (check one of the following):
☐ Houseless ☐ Living in other's homes ☐ Living in my home ☐ Jail / Incarcerated

Marital status (check one): ☐ Never Married ☐ Divorced ☐ Now Married
☐ Widowed ☐ Separated ☐ Living together

# of children living with you: ________ Ages: ____________ Pregnant: ☐ Yes ☐ No

Describe Current Legal Status: ______________________

____

Client Name: ______________
Date: ______________

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1. Have you been in a controlled environment in the past 30 days? ☐ Yes ☐ No

   ☐ Jail ☐ Alcohol/drug treatment ☐ Medical treatment ☐ Psychiatric treatment
   ☐ Other: ______________________________

2. Do you need transportation assistance? ☐ Yes ☐ No
3. Do you consume tobacco products? ☐ Yes ☐ No
4. In the last 30 days have you misused alcohol or other drugs? ☐ Yes ☐ No
5. Are you an Injection Drug User? ☐ Yes ☐ No
6. Have you ever felt you should cut down on your drinking or drug use? ☐ Yes ☐ No
7. Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No
8. Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No
9. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)? ☐ Yes ☐ No
10. Current medical problems: ☐ Yes ☐ No PCP Doctor's Name: ______________________________
11. List medications currently using (over the counter and prescribed): ______________________________
12. Do you have any current medical or psychiatric concerns? ☐ Yes ☐ No

    ____

13. Do you have any chronic health conditions? ☐ Yes ☐ No

    ____

14. Do you have any mental health conditions? ☐ Yes ☐ No

    ____

15. Do you have a history of causing physical harm to others? ☐ Yes ☐ No

    If yes, current risk action: ______________________________

16. Do you have a history of causing physical harm to yourself? ☐ Yes ☐ No

    If yes, current risk action: ______________________________

17. What services are you interested in? ☐ Counseling ☐ Sober Living ☐ Outpatient

    ☐ Residential ☐ Other ______________________________

Client Name: ______________________________
Date: ______________________________