Client Intake Form

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PLEASE PRINT

Social Security Number	**Date**	**Client's Date of Birth**

Client's Legal Name	**Last**	**First**	**Middle**	**Subtitle**

Street Address 1	**Street Address 2**
OK to send mail: yes no	

City	**State:**	**Zip Code**	**E-Mail Address:**

Client Telephone	**Emergency Contact Person**				**Emergency Contact Telephone**
	Last	**First**	**Middle**	**Subtitle**	
Ok to ID: yes no					

Relationship of Emergency Contact to Client:

Spouse
Friend
Mother
Father
Legal Guardian
Other

Emergency Contact Gender:

Male
Female

Race/Ethnicity of Client:

(a) What is client's race?

White
Black
American Indian
Alaskan Native
Asian or Pacific Islander
Other

(b) What is client's Ethnicity?

Puerto Rican
Mexican
Cuban
Other Hispanic
Not of Hispanic Origin

Marital Status:

What is the client's present marital status?

1 Now Married
2 Widowed
3 Divorce
4 Separate
5 Never Married

Pregnancy:

Is the client pregnant (or does the client think she is pregnant?)

1 Yes Male
2 No

IV User?

1 Yes No

Would you like information on MAT (Medicated Assisted Treatment)

1 Yes No

Household Members:

How many persons (of all ages and relationships) live in the client's household most of the time? Include the client

# of People under 18 yrs old that belong to you:

How Many children live with client most of the time? Include all children, and stepchildren

Employment Status:

Full-time
Part - Time
Looking for work
Disable

Job Title:

Highest Education:

Currently Enrolled In school

Yes
No

Referral Source into agency:

What agency or individual referred the client to your agency

Annual Household Income:

Income Sourse:

Wages
Disability
Public Assistance
None

Client's Primary Health Insurance:

1 Private Insurance
2 BlueCross/ BlueShield
3 Medicare
4 Medicaid 5 HMO
6 Other None

VOTER REGISTRATION

I choose to (Please check one box)

Complete a Registration form here
I am registered already
Register by mail
I decline to register

Military Status

Yes
No

Tobacco Use:

Smoke Vapor
Dip/Snuff None

Perferred Method Of Contact:

Phone Text
E-Mail Mail

CLIENT TUBERCULOSIS RISK AND SYMPTOM SURVEY

Name: _____Client ID#: _____

Risk Assessment	YES	NO
Have you ever been diagnosed with or treated for TB?	☐	☐
Within the past 6 months, have you been around someone who has been diagnosed with or treated for TB?	☐	☐
Within the past 6 months, have you traveled to or lived in any of the following countries: Latin America, the Caribbean, Africa, Asia, Eastern Europe, or Russia?	☐	☐
Within the past 6 months, have you lived or worked in any of the following places: homeless shelter, jail, prison, or nursing home?	☐	☐
Do you currently have any condition that weakens your immunity or ability to fight disease?	☐	☐
Within the past 6 months, have you injected illegal or other drugs into your body which were not recommended by your doctor?	☐	☐

Current Symptom Survey	YES	NO
Have you had a cough for 3 weeks or longer which is much worse than a regular cough when you have a cold?	☐	☐
Have you lost more than 5 pounds for **no known reason**?	☐	☐
Have you coughed up blood?	☐	☐
Have you experienced frequent, **unexplained** fever lasting for 2 weeks or more?	☐	☐
Have you had unusual or heavy sweating, especially at night?	☐	☐
Have you experienced weakness or extreme fatigue?	☐	☐

If you answered "YES" to a current symptom, please explain: _____

Client Signature	Date
Administrative Signature	Date
Coordinator Signature	Date

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GAIN-Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS 2.0.3

What is your name? a._____ b. ____ c. _____
(First name) (M.I.) (Last name)

What is today's date? (MM/DD/YYYY) ____/____/_____

The following questions are about common psychological, behavioral, and personal problems. These problems are considered <u>significant</u> when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago" (2), "1 or more years ago" (1), or "Never" (0).	Past month	2 to 12 months ago	1+ years ago	Never
	3	2	1	0

IDScr

1. <u>When was the last time</u> that you had <u>significant</u> problems…
   a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? ☐ ☐ ☐ ☐
   b. with sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day? ☐ ☐ ☐ ☐
   c. with feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen? ☐ ☐ ☐ ☐
   d. with becoming very distressed and upset when something reminded you of the past? ☐ ☐ ☐ ☐
   e. with thinking about ending your life or committing suicide? ☐ ☐ ☐ ☐

EDScr

2. <u>When was the last time</u> that you did the following things <u>two or more times</u>?
   a. Lied or conned to get things you wanted or to avoid having to do something? ☐ ☐ ☐ ☐
   b. Had a hard time paying attention at school, work, or home? ☐ ☐ ☐ ☐
   c. Had a hard time listening to instructions at school, work, or home? ☐ ☐ ☐ ☐
   d. Were a bully or threatened other people? ☐ ☐ ☐ ☐
   e. Started physical fights with other people? ☐ ☐ ☐ ☐

SDScr

3. <u>When was the last time</u> that…
   a. you used alcohol or other drugs weekly or more often? ☐ ☐ ☐ ☐
   b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or feeling the effects of alcohol or other drugs? ☐ ☐ ☐ ☐
   c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people? ☐ ☐ ☐ ☐
   d. your use of alcohol or other drugs caused you to give up, reduce or have problems at important activities at work, school, home, or social events? ☐ ☐ ☐ ☐
   e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or that you used any alcohol or other drugs to stop being sick or avoid withdrawal problems? ☐ ☐ ☐ ☐

(Continued) After each of the following questions, please tell us the last time that you had the problem, if ever, by answering, "In the past month" (3), "2-12 months ago" (2), "1 or more years ago" (1), or "Never" (0).	Past month	2 to 12 months ago	1+ years ago	Never
	3	2	1	0

CVScr 4. When was the last time that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone?	☐	☐	☐	☐
b. took something from a store without paying for it?	☐	☐	☐	☐
c. sold, distributed, or helped to make illegal drugs?	☐	☐	☐	☐
d. drove a vehicle while under the influence of alcohol or illegal drugs?	☐	☐	☐	☐
e. purposely damaged or destroyed property that did not belong to you?	☐	☐	☐	☐

5. Do you have other significant psychological, behavioral, or personal problems that you want treatment for or help with? (If yes, please describe below) ..... Yes ☐ No ☐

v1. _____

v2. _____

v3. _____

6. What is your gender? (If other, please describe below) ……1-Male 2-Female 99-Other

v1. _____

7. How old are you today? |__|__| years

Trauma Screening

a. Have you been through any experience that caused you to think that you might get physically hurt or that you might not even live through it? ☐ No ☐ Yes

b. Have you been through any experience that caused you to feel that you would never be safe or secure again? ☐ No ☐ Yes

c. If you answered yes to question 1 or 2, is this situation current? ☐ No ☐ Yes

d. If you answered yes to question 1 or 2, would you like to be able to talk with someone in more detail about these experiences that you have been through? ☐ No ☐ Yes

Family Assessment Form

In order for the staff of the Phoenix Center to effectively treat your child, it is important that we obtain not only his/her perspective but also your perspective. Please take a few minutes to fill out this Assessment Form. If you have any questions, please feel free to discuss them with the Intake Counselor.

Client Name:_____ Your Name and Relation: _____

1. Please list the name, age, and relation of everyone living in the home with your child.
   _____
   _____
   _____

2. Briefly describe the relationship between your child and the above members of the household. (For example: who gets along well, who has a strained relationship).
   _____
   _____
   _____
   _____

3. Do you feel your child is in need of Substance Abuse Treatment? _____ Explain:
   _____
   _____
   _____

4. Describe in your own words what you feel your child's problems are: _____
   _____
   _____
   _____
   _____

5. Please list any previous counseling/treatment services your child has received (where and when). _____
   _____
   _____
   Do you feel this service was beneficial? ____ Explain: _____
   _____
   _____

6. Is your child currently taking or supposed to be taking any prescribed medications? _____
   _____

   Has your child been prescribed medications in the past to control mood or behavior? ____ If yes, what was prescribed and who prescribed ? _____
   _____
   _____

7. Are there any family members whom currently drink alcohol or use any other drugs? _____ If yes, please list relation to child. _____

8. Are there any family members who had a problem with alcohol or other drugs but are currently not using?_____ If yes, please list relation to child and number of weeks, months or years this person(s) has been alcohol/drug free. _____

9. Is there any family members (past or present) whom have had mental health problems? _____ If yes, please list relation and nature of problem(s).

10. Has your child ever experienced any trauma (physical/sexual abuse, rape, victim of violent assault, witness to a murder or of a death)? _____

11. Please describe how you discipline you child. _____

12. Please describe in your own words the strengths of your child. _____

13. Please describe in your own words your views of alcohol and/or drug addiction.

14. What other information do you feel would be helpful to the staff treating your child?