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's Treatment Plan Worksheet

What do you hope to get out of participating in services here?

What area(s) do you hope will change in your life as a result of coming to counseling?

How will you know when these changes happen?

What can you do to make these changes happen?

What things exist in your life now that will work against you in making these changes?

What things exist in your life now that will be helpful to you in making these changes?

Client Signature **Date**

Clinician Signature, Title **Date**

BEHAVIORAL HEALTH SCREEN

Client Name: _____ **Date:** _____

Number of DUI arrests in your lifetime. _____ Was your DUI dropped to reckless driving? ☐ Yes ☐ No

Have you attended ADSAP or another DUI program in the past? ☐ Yes ☐ No

Describe where/when/why you attended another ADSAP/DUI program?

Have you driven under the influence more than once in the past 10 years? ☐ Yes ☐ No

Number of speeding tickets in the past 10 years? _____

Number of alcohol related arrests in the past 10 years? _____

Do you have a pending DUI arrest that you have not yet gone to court on? ☐ Yes ☐ No

When is the last time you used any alcohol or drugs, and how much and for how have you been using?

Please answer "YES" or "NO" to the following questions:	**Yes**	**No**
Have you attended detox, inpatient or other outpatient programs for alcohol or drug use in the past?	☐	☐
Do you have any medical issues?	☐	☐
Are you supposed to be taking any medications?	☐	☐
Have you had prior alcohol or drug related arrests?	☐	☐
Have you ever wanted to stop drinking/using but have been unable to do so?	☐	☐
Do you feel like you are in danger of harming yourself or someone else?	☐	☐
Have you suffered/still suffer with depression, anxiety or other mental health problems in the past?	☐	☐
Do you gamble?	☐	☐
Have you gambled in the past?	☐	☐
Have you ever thought you had a problem with gambling?	☐	☐
Has anyone ever told you they thought you had a gambling problem?	☐	☐
Do you have insurance or Medicaid?	☐	☐

BEHAVIORAL HEALTH SCREEN

How often do you have a drink containing alcohol?

☐ 2-3 times per week ☐ 2-4 times per month ☐ Monthly or less ☐ Never

How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 10 or more

Please check the appropriate answer for the following questions:	**Daily or almost daily**	**Less than monthly**	**Monthly**	**Weekly**	**Never**
How often do you have six or more drinks on one occasion?	☐	☐	☐	☐	☐
How often in the last year have you found that you were unable to stop drinking once you had started?	☐	☐	☐	☐	☐
How often in the last year have you failed to do what was expected from you because of your drinking?	☐	☐	☐	☐	☐
How often in the last year have you been unable to remember what happened because of your drinking?	☐	☐	☐	☐	☐
How often in the last year have you drank alcohol upon waking up to help you get going?	☐	☐	☐	☐	☐
How often during the last year have you had a feeling of guilt or remorse after drinking?	☐	☐	☐	☐	☐

Have you or someone else been injured as a result of your drinking?

☐ No ☐ Yes, but not in last year ☐ Yes, during last year

Has a relative, friend, doctor, or another health professional expressed concern about your drinking?

☐ No ☐ Yes, but not in last year ☐ Yes, during last year

Please answer "YES" or "NO" to the following questions:	**Yes**	**No**
Have you used drugs other than those required for medical reasons?	☐	☐
Do you abuse more than one drug at a time?	☐	☐
Are you always able to stop using drugs when you want to? If you never use drugs, check yes.	☐	☐
Have you had blackouts or flashbacks as a result of drug use?	☐	☐
Do you ever feel bad or guilty about your drug use?	☐	☐
Does your spouse (or parents) ever complain about your involvement with drugs?	☐	☐
Have you neglected your family because of your use of drugs?	☐	☐
Have you engaged in illegal activities in order to obtain drugs?	☐	☐
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐	☐
Have you had medical problems as a result of your drug use?	☐	☐

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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INSTRUCTIONS FOR FOLLOW-UP BASED ON SURVEY RESULTS

This form is to be completed by all clients who present for admission. It must be completed and reviewed by staff before the client is brought into an outpatient counselor's office. These questions are also asked during the phone screen for any individual who is seeking admission to Detoxification, Serenity Place, and White Horse Academy. The answers are documented on the program's phone screen form.

If any one of the risk assessment questions in section 1 is answered yes, the individual is encouraged to consider receiving a TB skin test.

If any one of the current symptom questions in section 2 is answered yes and the individual is unaware of any other medical condition which is related to the symptom, the individual is required to complete a TB skin test or chest x-ray before returning for other services. Documentation of a negative skin test or chest x-ray is required before the individual is assessed on site or admitted into services.