

Client Intake Form

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: <input type="checkbox"/> yes <input type="checkbox"/> no					
City		State:		Zip Code	
				E-Mail Address:	
Client Telephone ()		Emergency Contact Person			Emergency Contact Telephone ()
Ok to ID: <input type="checkbox"/> yes <input type="checkbox"/> no		Last	First	Middle	Subtitle
Relationship of Emergency Contact to Client:		Race/Ethnicity of Client:		Marital Status:	
<input type="checkbox"/> Spouse <input type="checkbox"/> Friend <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other		(a) What is client's race? <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Other		What is the client's present marital status? 1 <input type="checkbox"/> Now Married 2 <input type="checkbox"/> Widowed 3 <input type="checkbox"/> Divorce 4 <input type="checkbox"/> Separate 5 <input type="checkbox"/> Never Married	
Emergency Contact Gender:		(b) What is client's Ethnicity?		Pregnancy:	
<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Puerto Rican <input type="checkbox"/> Mexican <input type="checkbox"/> Cuban <input type="checkbox"/> Other Hispanic <input type="checkbox"/> Not of Hispanic Origin		Is the client pregnant (or does the client think she is pregnant?) 1 <input type="checkbox"/> Yes 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> No	
Household Members:		# of People under 18 yrs old that belong to you:		IV User?	
How many persons (of all ages and relationships) live in the client's household most of the time? Include the client		How Many children live with client most of the time? Include all children, and stepchildren		1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No Would you like information on MAT (Medicated Assisted Treatment) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Employment Status:		Highest Education:		Referral Source into agency:	
<input type="checkbox"/> Full-time <input type="checkbox"/> Part - Time <input type="checkbox"/> Looking for work <input type="checkbox"/> Disable				What agency or individual referred the client to your agency	
Job Title:		Currently Enrolled In school		Annual Household Income:	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Wages 3 <input type="checkbox"/> Public Assistance <input type="checkbox"/> Disability 4 <input type="checkbox"/> None	
				Income Source:	
				6 <input type="checkbox"/> Other 7 <input type="checkbox"/> None	
VOTER REGISTRATION			Military Status		Tobacco Use:
I choose to (Please check one box) <input type="checkbox"/> Complete a Registration form here <input type="checkbox"/> Register by mail <input type="checkbox"/> I am registered already <input type="checkbox"/> I decline to register			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Smoke <input type="checkbox"/> Vapor <input type="checkbox"/> Dip/Snuff <input type="checkbox"/> None
Perferred Method Of Contact:					
<input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> E-Mail <input type="checkbox"/> 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

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 <u>no known reason</u> ?		
Have you coughed up blood?		
Have you experienced frequent, <u>unexplained</u> 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

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.