



INTAKE SCREENING FORM

Client Last Name _____ Client First Name _____ MI _____

FEMALE/MALE Client Date of Birth: _____ Client's Mother's First Name: _____

Client Billing Address: _____
Street City/State Zip Code + 4 digit code

Client Phone Number: _____ Client Social Security Number: _____

Pharmacy: _____ Drug Allergies: _____

We put everyone on a sliding fee scale regardless of income and insurance status. Please fill out the following...

EARNED HOUSEHOLD INCOME (monthly or yearly – i.e. wages): _____ -

UNEARNED HOUSEHOLD INCOME (monthly or yearly – i.e. TANF, SSDI, Child

Support): _____

NUMBER OF PEOPLE IN YOUR HOUSEHOLD (only include people you support): _____

IF YOU ARE ON INSURANCE OR MEDICAID PLEASE GIVE A COPY TO THE SUPPORT STAFF SO THAT OUR BILLING OFFICE CAN CORRECTLY BILL YOUR CHARGES. IF INFORMATION IS MISSING YOU MAY BE SET UP AS SELF PAY AND FULL RATE. THANK YOU!

Self Pay Court Services Medicare

Medicaid/T19 number: _____

Insurance Company: _____
Insurance ID: _____ Insurance Group #: _____
Policy Holder: _____ DOB: _____ Social Security Number: _____

EAP thru _____ Number of free sessions: _____
Authorization/Reference Number: _____

Tricare: Sponsor Name: _____ Sponsor Date of Birth: _____
Sponsor SSN and Benefit ID number: _____ ACTIVE DUTY/RETIRED

*****PLEASE ENTER INFORMATION FOR CLIENT:**

Emergency Contact: _____ Relationship: _____
Emergency Contact phone number: _____

***** PLEASE TURN OVER *****

DEMOGRAPHIC INFORMATION FOR CLIENT

Did anyone refer you to BMS: _____ Highest Grade Completed: _____

Are you a veteran:

No
 Yes

English Proficiency:

Full
 Limited
 Requires Assistance

Special Education:

No
 Yes

Adult Living Status:

(Client 18 +)

Alone/Independently
 with spouse and children
 With spouse only
 With other family member
 With unrelated person
 With parents
 Group Home
 Nursing Home
 Supportive Living (supervised apartment)
 Transitional Family
 Adult Foster Care
 Other
 Homeless

If Homeless:

continuously for 1+ years
 4 + episodes in past 3 years
 neither of the above

Smoker:

No
 Yes

Primary Race:

Alaska Native
 American Indian
 Asian
 White
 African American
 Other

Ethnicity:

Puerto Rican
 Mexican
 Cuban
 Other specific Hispanic
 Hispanic - Origin no specified
 Not of Hispanic Origin

Marital Status:

Married
 Single
 Separated
 Divorced
 Widowed

Employment Status:

Full Time
 Part Time
 Unemployed but looking for job
 Not in labor force

Not in Labor Force reason:

Homemaker
 Retired
 Student
 Disabled
 Inmate
 Other
 Not Applicable

Length of Employment or

Not in Labor Force:

Less than 6 months
 1 year
 2 - 4 years
 5 - 7 years
 8 - 15 years
 16 + years

Referral Source:

Family/Self/Friend
 Dept of Social Services
 Court/Attorney
 Employer/EAP
 Community Mental Health
 Hotline
 Human Services Center
 School
 Alcohol/Drug provider
 Vocational Rehab
 Child/daycare provider
 Indian Health Service

IF CRIMINAL JUSTICE REFERRAL:

State/Federal Court
 Attorney
 Department of Corrections
 Federal Probation
 Law Enforcement
 Prison

Department of Disability
 Clergy
 Veteran's Administration
 Medical Physician

Public Health Service
 Other Social Services
 College/University
 Other

State's Attorney
 Other
 Not applicable