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: ______________

EARNED **HOUSEHOLD INCOME** (monthly or yearly – ie. wages) :_____-
____

UNEARNED **HOUSEHOLD INCOME** (monthly or yearly – ie. TANF,SSDI, Child Support):______________

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

We will use this information to put you on the sliding fee scale regardless if you have insurance

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. THANKS!

○ Self Pay ○ Court Services

○ EAP thru ______________ Number of free sessions: ______________
Authorization/Reference Number: ______________

○ Medicaid/T19 number: ______________

○ Insurance Company: ______________ Policy #:______________ Group #:______________
Primary Policy Holder: ______________ DOB: ______________ SSN: ______________

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

Responsible Party/Guardian Name: ______________
Responsible Party/Guardian Address: ______________
Relationship to Client: ______________

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

Emergency Contact: ______________ Relationship: ______________

Emergency Contact phone number: ____

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

DEMOGRAPHIC INFORMATION FOR CLIENT

How did you hear about us: ______________________________ Highest Grade **CLIENT** Completed: _______

Special Education:
____ No
____ Yes

English Proficiency:
____ Full
____ Limited
____ Requires Assistance

Child Living Arrangement:
(client 17 and under)
____ Both Parents
____ Single Parent
____ Foster Home
____ Other relative
____ Parent/Step parent
____ Therapeutic foster care
____ Independent living
____ Private Care Facility
____ Public Care facility
____ Other
____ Homeless

If Homeless:
____ Continuously for 1+ years
____ 4 + episodes in past 3 years
____ Neither of the above

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

Referral Source:
____ Family/Self/Friend
____ Dept of Social Services
____ Court/Attorney
____ Employer/EAP
____ Community Mental Health
____ Hotline
____ Department of Disability
____ Clergy
____ Veteran's Administration
____ Medical Physician
____ Human Services Center
____ School
____ Alcohol/Drug provider
____ Vocational Rehab
____ Child/daycare provider
____ Indian Health Service
____ Public Health Service
____ Other Social Services
____ College/University
____ Other

IF CRIMINAL JUSTICE REFERRAL:
____ State/Federal Court
____ Attorney
____ Department of Corrections
____ Federal Probation
____ Law Enforcement
____ Prison
____ State's Attorney
____ Other
____ Not applicable