



Client Intake Form

Client Information

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|---|---|---|--|-----|
| Date: | | Time: | | |
| Last Name: | | First Name: | | MI. |
| Preferred Name: | Date of Birth (mm/dd/yyyy): <input type="checkbox"/> | Gender: Male Female | | |
| Current Address: | Phone Number (If Any): | | | |
| Social Security Number: | Are You Pregnant? Yes No | Are You Veteran or active Military? Yes No | | |
| Marital Status: Never Married Married Divorced Separated Widowed | Sexual Orientation: Heterosexual Gay/Lesbian Bisexual Decline/Other | Ethnicity: American Indian/Alaskan Native Asian Black/African American Native Hawaiian/ Pacific Islander White Declined/Other | | |

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| Are there any identified, past or current, domestic violence issues? (If so, describe) | Yes No |
| Is this person at the risk of homelessness? (If so, describe) | Yes No |
| Length of Homelessness episode: | <1 Mo. <6 Mo. <1 Yr. >3 Yrs. |
| Does applicant have a long duration disability? | Yes No |
| Current Diagnosis | Mental Illness Alcohol Abuse Drug Abuse Physical Disability Developmental Disability Others (Specify) |
| Where does applicant receive medical care? | |
| Does applicant have any current legal issues? | Yes No |
| Is applicant currently on parole? | Yes No |

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|--------------------------------------|---------------|
| Case Manager's Name / Employer: | Phone Number: |
| Legal Guardian's Name / Employer: | Phone Number: |
| Emergency Contact's Name / Employer: | Phone Number: |

Supervisor's Initial: _____

Client or Client rep's Initial: _____

Financial Responsibility Information

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| Payment Method: RSS/SSI Private Pay Other | RSS Application Number: |
| Filing Date: | Approval Status: |
| First Day of Prorated payment: | Fee Agreement: |

Additional Benefits

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| Frequent Laundry: Personal care: Transportation: Additional Meals: |
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Physical Conditions (example: Dental, Mobility, surgeries, etc.)

No known physical conditions

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Current Medications

No current medication

| Medication name | Strength (example: 50mg) | Frequency (example: at bedtime, 2x/day, etc.) | Prescribing Physician |
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Medication Allergies

No known medication allergies

| Medication | Reaction (example: hives, rash, etc.) | Medication | Reaction (example: hives, anaphylaxis, etc.) |
|------------|---------------------------------------|------------|--|
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Supervisor's Initial: _____

Client or Client rep's Initial: _____