Non-Medical Respite Home Intake Form

Intake Date: _____

General Client Information:

Name:	**ID#:**	**DOB:**	**Age:**	**Identified Gender:**
Date of Last Hospital Admission:		**Name of Hospital:**		**Length of Stay:**

What is your primary language?_____

Current Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated ☐ Civil Union

☐ Other_____

Religious background: _____

Do you have children? ☐ Yes ☐ No If yes, how many?_____

How old are your children? _____

Who is caring for your children now?_____

Have you ever served in the United States Military? ☐ Yes ☐ No If yes, what branch? _____

How long did you serve? _____ Type of discharge_____

Immigration Information

Are you a US citizen? _____ If not, what is your immigration status? _____

Other immigration information:_____

Housing:

Housing Status Prior to Treatment:

☐ Homeless ☐ Renter ☐ Own ☐ Living with family/friends ☐ Living on the streets

What is your current housing situation? _____

_____

What are your plans for housing after completing the program?_____

_____

_____

Do you have a voucher for housing? ☐ Yes ☐ No

- Currently on the housing waiting list with..... ☐ Yes ☐ No
- Are you currently on any housing waiting lists? ☐ Yes ☐ No
  - If yes, specify waiting list:_____

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Past Housing History:

- Ever lived alone? ☐ Yes ☐ No
- Ever been evicted? ☐ Yes ☐ No
  - If yes, indicate the reason: _____
- Stayed in a group home/Shelter? ☐ Yes ☐ No
- Had Roommates? ☐ Yes ☐ No
- Had any trouble paying rent/bills? ☐ Yes ☐ No

Other Housing Information:

_____

_____

_____

_____

Employment/Financial

Are you currently working? ☐ Yes ☐ No

If yes, where? _____ ☐ Full Time ☐ Part time

Does your current employer know about your situation? ☐ Yes ☐ No

If unemployed, what kind of work/job have you had in the past (Dates Employed and length)?

_____

_____

_____

_____

Do you receive public benefits? ☐ Yes ☐ No

If yes, what benefits are you receiving:

☐ Food stamps ☐ SSI/SSDI _____ (Amount) ☐ Unemployment ☐ WIC

☐ IDA_____ ☐ TANF _____ (Amount) ☐ Other_____

How do you handle your finances? _____

Have you ever maintained a budget? ☐ Yes ☐ No

If Yes, what is your experience with budgeting? _____

_____

Do you have financial institution? ☐ Yes ☐ No If yes, what institution? _____

Checking or Savings account? _____

Other Employment/Finance Information: _____

_____

_____

_____

Education:

What is the highest grade completed in school/education obtained? _____

Have you completed any of the following (check all that apply):

☐ GED ☐ High School diploma ☐ Vocational Certificate/Program

☐ Some College ☐ Bachelor's Degree or higher

Other education or training:

_____

_____

_____

_____

Disability Challenges

Do you have a disability or other learning or physical challenge that you may need an accommodation during your time at Harbor Light Center? ☐ Yes ☐ No

If yes, what is your disability and what accommodation is needed? _____

_____

Additional notes on disability (as needed):_____

_____

_____

Substance Use History/Treatment

Do you have any substance use history? ☐ Yes ☐ No

How old where you when you first used drugs?_____ What was your first drug used? _____

What is your primary drug of choice? _____

Frequency of use: _____ Other: _____

When did you start using your primary drug of choice? _____

What is your secondary drug of choice? _____

Have you ever enrolled in inpatient or outpatient substance abuse treatment? ☐ Yes ☐ No

If yes, Where and when?_____

_____

Relapse History (Periods of clean time. What was going well for or with the client during that time? Reason for resumption of use):_____

_____

_____

_____

Health History (mental and physical health)

Do you have any mental health diagnoses? ☐ Yes ☐ No

If yes, what your diagnosis? _____

When were you diagnosed?_____

What mental health services are you currently receiving?

☐ No Prior Service ☐ Psychiatry/Therapy only_____

☐ Core Service Agency (i.e. MBI, Community Connections, etc.) _____

☐ Dept. of Behavioral Health

Do you currently have any medical conditions? ☐ Yes ☐ No

If yes, please list them: _____

Are you currently taking any medications for mental health or medical conditions? ☐ Yes ☐ No

Did you bring a 30-day supply of your medications or prescriptions? ☐ Yes ☐ No

Please list any medications you are currently taking:

Medication Name	Dosage	Frequency	Type of Medication (Mental Health/Medical)

Do you have medical insurance? ☐ Yes ☐ No

If yes, who are you insured with? _____

Do you have a primary care physician? ☐ Yes ☐ No

If yes, where do you receive medical services: _____

_____

_____

Additional information re: medical issues or mental health issues:

_____

_____

_____

Legal History

Have you ever been incarcerated? ☐ Yes ☐ No If yes, how long did you spend incarcerated? _____

Of which crime or crimes were you accused or convicted? _____

_____

_____

Do you have any upcoming court dates? ☐ Yes ☐ No If yes, when are they scheduled? _____

Do you have any outstanding warrants that you are aware of? _____

What is your current community supervision requirements?

What is the name of your CSO/parole officer/Pre-Trial Services officer? _____

What is her/his phone number? _____ Email address? _____

Additional notes regarding legal history (if needed):

_____

_____

_____

_____

Trauma History

*According to the Substance Abuse and Mental Health Services Administration (SAMHSA), the working definition of individual trauma is, "*that which results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being."

Based on that definition, we are going to explore whether you have experienced trauma over the course of your life (nearly everyone has) by asking whether you have ever experienced or witnessed the following:

a. Victim of a shooting ☐ Yes ☐ No
b. Major car accident ☐ Yes ☐ No
c. Stab or seriously wounded ☐ Yes ☐ No
d. Caught in a fire ☐ Yes ☐ No
e. Survivor of childhood physical abuse & neglect ☐ Yes ☐ No
f. Survivor of domestic violence ☐ Yes ☐ No
g. Rape Survivor ☐ Yes ☐ No
h. Survivor of childhood sexual violence ☐ Yes ☐ No

g. Traumatic Grief ☐ Yes ☐ No

k. Medical Trauma ☐ Yes ☐ No

l. Traumatic pregnancy ☐ Yes ☐ No

m. Death of a child ☐ Yes ☐ No

n. Murder ☐ Yes ☐ No

Additional notes about trauma history (as needed):

_____

_____

_____

_____

Services Needed:

- Housing: _____
- Employment: _____
- School/Education Needs: _____
- Daily Living Skills: _____
- Financial Planning:_____
- Counseling: _____
- Medical/Health: _____
- Food/Clothing: _____
- Resources_____

- Legal Services_____
- Public Benefits_____
- ID/Social Security Card_____
- Other: _____

Additional Information:

_____

_____

_____

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Client Profile & Current Support Network

What are your identified strengths and challenges?

_____
_____
_____

Who do you identify as your support system/network?

_____
_____
_____

Any Background history client shared during intake:

_____
_____
_____
_____

Client stated discharge Plan:

_____
_____
_____
_____
_____

Recommendation for treatment plan based on the case management intake:

Goals: _____

Objective: _____

Intervention: _____

Goals: _____

Objective: _____

Intervention: _____

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INTAKE NOTES (attach additional sheets as needed)

Signature of Person Conducting Interview | Print Name | Date

Signature of Clinical Supervisor/Director | Print Name | Date