Foundations Behavioral Health Services, Inc.
Client Intake

Services Requested: ☐ Mental Health ☐ Substance Use (Alcohol/Drug)
Are you a previous client of Foundations BHS? ☐ Yes ☐ No ☐ Unsure

Name:_____
First **Middle** **Last**

Phone Number:_____ **Secondary Phone Number:**_____
(Cell, Home, Work) (Cell, Home, Work)

Address: _____
Street/Apt # City/State/Zip Code County

E-Mail Address:_____

Confirmation of Appointments:

- ☐ Confirm the appointment directly with me only.
- ☐ Leave telephone message with the following household member:_____
- ☐ Leave telephone message on answering machine.
- ☐ Do not confirm my appointments.

Emergency Contact:_____ **Phone Number:**_____

Living Situation: My Home: ☐ Rent ☐ Own
Other: ☐ Hospital ☐ Temporary Housing ☐ Residential Care ☐ Nursing Home
☐ Respite Care ☐ Friends House ☐ Foster Care Home
☐ Relative/Guardian's Home ☐ Jail/Prison ☐ Homeless/In Shelter
☐ Other (If other, please identify facility): _____

Date of Birth:_____ **Age:**_____ **Gender:** ☐ Male ☐ Female

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Other:_____

Ethnicity: ☐ Mexican ☐ Cuban ☐ Marshallese ☐ Non-Hispanic or Latino ☐ Other Hispanic

Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

Primary Language: ☐ English ☐ Marshallese ☐ Hispanic ☐ Other:_____

Military Service:_____

Social Security Number:_____

FOR OFFICE USE ONLY
Received by:_____ **Date:**_____ **Time:**_____
Closing Date:_____

Who referred you to Foundations?_____

If Client is a minor, who has legal custody:_____
(Name of Legal Custodian)

Employment History

Client's Occupation:_____ ☐ Full Time ☐ Part Time
Employer:_____ How long?_____
☐ Unemployed/Date Last Worked:_____
Number of jobs in the past five years:_____

Not in labor force:
☐ Disabled ☐ Retired ☐ Homemaker ☐ Student ☐ Living in Institution
☐ Other (please indicate):_____

Education History (check all that apply):

☐ GED ☐ High School Graduate Highest Grade Completed:_____
☐ College Number of Years:_____ Degree/Major:_____

Were you ever placed in any special education classes? ☐ Yes ☐ No
If yes, what type:_____

Household Member Names	**Relationship to Client**	**Age**	**Quality of Relationship (check one)**
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor
Significant Family Members/ Others Not Listed Above	**Relationship to Client**	**Age**	**Quality of Relationship (check one)**
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor
			☐ Good ☐ Fair ☐ Poor

Primary Care Physician (name, phone number and address):_____
Date of last physical exam:_____
Other Prescribing Physician(s): _____

Physical Health: General Health_____ Height:_____ Weight:_____

Major illnesses, hospitalizations:

Please indicate number of visits to the following HEALTH CARE FACILITIES (in the past 12 months):

Hospital admissions:_____ Emergency room admissions/visits:_____

Regular visits to the Doctor:_____ Regular visits to the Dentist:_____

Outpatient health care admissions/visits:_____

Any current allergies?:_____

Current Problems:

☐ Frequent headaches	☐ Abdominal Pain	☐ Sexual Problems
☐ Vision Problems	☐ Nausea or Vomiting	☐ Hearing Problems
☐ Paralysis or Weakness	☐ Eating Problems	☐ Buzzing/Ringing in Ears
☐ Numbness	☐ No Energy	☐ Chest Pain
☐ Seizures	☐ Dizziness/Fainting	☐ Back Pain
☐ Breathing Problems	☐ Handicap	☐ Pregnancy

☐ Other:_____ Date of last menstrual period:_____

Family Health History:

☐ Diabetes	☐ Cancer	☐ Blood Clotting Problem
☐ High Blood Pressure	☐ Heart Problems	☐ Epilepsy
☐ Stroke	☐ Tuberculosis	☐ Mental Illness

☐ Other:_____

Past Psychotropic Medications: ☐ **None Reported**

Psychotropic Medications:	Reason for Discontinuation:

If you have a legal guardian and/or representative payee, please indicate below:

Name:_____

Address: _____

Street Address/Apt No City/State Zip Code

Phone: _____

Is your visit here a result of being a victim of crime? ☐ Yes ☐ No

Are you on probation or involved in drug court? ☐ Yes ☐ No

_____ _____

Client (Parent/Guardian) Signature **Date**