



NHP INTAKE FORM

Date: _____

Identified Client:			
	First Name	MI	Last Name

Address				
	Number & Street	City	State	Zip

Telephone			
	Day	Evening	Emergency

Medical Coverage				
	Parent	Child	Expiration Date	ID Number

Identified Client is:			
	Child	Age	Caretaker

Gender			
	Male	Female	Transgender

Race\Ethnicity				
	African-American	Hispanic/Latino	Asian	Native American

<i>Cont.</i>				
	Caucasian	Haitian Creole	Cape Verdean	Other (Please Name)

Biracial		
	Mother's Race\Ethnicity	Father's Race\Ethnicity

Children in Family						
	<i>Mother's Family</i>	Girls	Boys	<i>Father's Family</i>	Girls	Boys

Housing Difficulties	Present at referral			
	Yes	No		If Yes, Type of difficulty

Guardian				
	Mother	Father	Other (describe)	Type of Employment

Domestic Violence				
	Mother	Father	Other (describe)	Any domestic violence in the past 6 months? (describe)

<i>Cont.</i>		
	Does perpetrator live in the home?	Other information on perpetrator

Current Hospitalization				
	Yes	No	Reason	Hospital

Past Hospitalization(s)					
	Yes	No	Reason(s)	No. Times	Hospital



Intake form continued

Ideations\Gestures	<i>Suicide</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Homicide</i>	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe)
		Yes	No		Yes	No	

DSM-IV Diagnosis	Describe
-------------------------	----------

Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	History
	Yes	No	

Sex Abuse	<input type="checkbox"/>	<input type="checkbox"/>	History
	Yes	No	

Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	History
	Yes	No	

Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	History
	Yes	No	

Running	<input type="checkbox"/>	<input type="checkbox"/>	History
	Yes	No	

Referred Child is in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Psychiatric Hospital	Residential Facility	Own Family Home	Foster Care	Group Home	Other (describe)

System Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	DSS	DVR	DYS	DMH	CHINS	Other (describe)

Intake Team	
--------------------	--

Client Strengths\Interests:

Additional Comments: