Intake Form

Date:________________________________ Referred By: ________________________________

Name: ____

Phone Number: ____

Email: _________________________________ Religious Affiliation: _______________________

Where are you currently staying? City?: ____

Birthdate: ____ Age: ____________________

Place of Birth: ___________________________ Citizenship: ______________________________

Race: _______________________ Social Security Number: ______________________________

Marital Status: ____ Single ____ Married ____ Divorced ____ Engaged ____ Separated

Do you own a car? __ Yes __ No In your name? __ Yes __ No Is it paid off? __ Yes __ No

Do you have a valid Driver's License? __ Yes __ No Do you have car insurance? __ Yes __ No

Section 1

1) Are you currently pregnant? ☐ Yes ☐ No
2) How many weeks pregnant are you? ____
3) What is your expected due date? ____
4) What was the date of your last prenatal doctor visit? ____________________________
5) Doctor's Name: ____
6) Doctor's Phone Number: ____
7) How are you feeling about your pregnancy?
   ____
   ____
   ____
8) Are you having a boy or a girl? ____

Section 2

1) Are you receiving WIC at this time? ☐ Yes ☐ No

2) Are you on any type of government assistance? ☐ Yes ☐ No

If you answered yes, please list which ones.

____
____

3) Do you have insurance?

( ) Medicaid ( ) Medicare

( ) Private ( ) Medical Assistance

( ) VA ( ) None

( ) Other : ____

Section 3

1) Do you have any of the following?

Mental Health Issues	☐	Yes	☐	No	Explain: ____________________________
Drug Issues	☐	Yes	☐	No	Explain: ____________________________
Alcohol Issues	☐	Yes	☐	No	Explain: ____________________________
Asthma	☐	Yes	☐	No	Explain: ____________________________
Diabetes	☐	Yes	☐	No	Explain: ____________________________
Allergies	☐	Yes	☐	No	Explain: ____________________________
Developmental Disability	☐	Yes	☐	No	Explain: ____________________________
Physical Disability	☐	Yes	☐	No	Explain: ____________________________
HIV/AIDS	☐	Yes	☐	No	Explain: ____________________________

Victim of Domestic Violence	☐ Yes	☐ No	Explain: ___________________________________
Chronically Mentally Ill	☐ Yes	☐ No	Explain: ___________________________________
Special Needs	☐ Yes	☐ No	Explain: ___________________________________
Unspecified Disability	☐ Yes	☐ No	Explain: ___________________________________
Communicable Illness	☐ Yes	☐ No	Explain: ___________________________________
Tuberculosis	☐ Yes	☐ No	Explain: ___________________________________
Learning Disability	☐ Yes	☐ No	Explain: ___________________________________
Lupus	☐ Yes	☐ No	Explain: ___________________________________
Attention Deficit Disorder	☐ Yes	☐ No	Explain: ___________________________________

1) Are you on medication? ☐ Yes ☐ No

   If yes, please list and explain:
   ____
   ____

2) Do you have any other health problems? ☐ Yes ☐ No

   If yes, please explain:
   ____
   ____

3) Are there any emotional problems in your family? ☐ Yes ☐ No

If yes, please explain:

____

____

4) History of drug or alcohol abuse in your family? ☐ Yes ☐ No
If yes, please explain:

____

____

5) Have you used:

Alcohol	☐ Yes	☐ No	First Time __________	Last Time __________
Marijuana	☐ Yes	☐ No	First Time __________	Last Time __________
Cocaine/Crack	☐ Yes	☐ No	First Time __________	Last Time __________
Heroin	☐ Yes	☐ No	First Time __________	Last Time __________
Meth	☐ Yes	☐ No	First Time __________	Last Time __________
Prescription Drugs	☐ Yes	☐ No	First Time __________	Last Time __________
Pain Killers	☐ Yes	☐ No	First Time __________	Last Time __________

6) Do you smoke? ☐ Yes ☐ No

<u>Section 4</u>

Your Mother's Name: ____

Whereabouts: ____

Your Father's Name: ____

Whereabouts: ____

What is your relationship like with your family?

____

____

____

Do you know who the father is? ☐ Yes ☐ No

Baby's Father's Name: ____

Whereabouts: ____

How did you meet?____

How long have you known him? ____

What do you like about him? ____

Can you describe his personality? ____

Does he know you are pregnant? ☐ Yes ☐ No

How does he feel about it? ____

Does he have a history of drug use? ☐ Yes ☐ No

Have you used drugs together? ☐ Yes ☐ No

Does he own a weapon? ☐ Yes ☐ No

Has he threated you? ☐ Yes ☐ No

Has he threated others? ☐ Yes ☐ No

What is your relationship like with your baby's father?

____
____
____

Section 5

Have you been pregnant before? ☐ Yes ☐ No If yes, how many times? ______________

Do you have any children? ☐ Yes ☐ No

Please list all of your children's names:

Child's First Name: ______________________ Last Name: ______________________

Age: ______________ Date of Birth: ________________ Gender: ______________

Child's Father's Name: ____

Who has legal custody? ____

Child's First Name: ____________________________ Last Name: __________________________

Age: ___________________ Date of Birth: ______________________ Gender: ________________

Child's Father's Name: ____

Who has legal custody? ____

Child's First Name: ____________________________ Last Name: __________________________

Age: ___________________ Date of Birth: ______________________ Gender: ________________

Child's Father's Name: ____

Who has legal custody? ____

Child's First Name: ____________________________ Last Name: __________________________

Age: ___________________ Date of Birth: ______________________ Gender: ________________

Child's Father's Name: ____

Who has legal custody? ____

Section 6

Have you experienced physical, emotional, or verbal abuse? (Please Explain)

____

____

Have you experienced sexual abuse? (Please Explain)

____

____

Is your family aware of this?____

Have you ever sought counseling? ____

Are you in danger? ______________ By Whom? ____

Section 7

Are you currently under court authority, including DFS, for any reason? ☐ Yes ☐ No

If yes, explain:

____

____

Are you on probation or parole? ☐ Yes ☐ No

If yes, explain:

____

____

Do you have any pending charges? ☐ Yes ☐ No

If yes, explain:

____

____

Do you have any prior convictions? ☐ Yes ☐ No

If yes, explain:

____

____

Do you acknowledge that we will run a background check before you are accepted into Lori's House? ☐ Yes ☐ No

Signature: ____ Date: ____________________________

Section 8

Who might visit you while you are here?

____
____

How will this program help you?

____
____

What are your views on God?

____
____

How do you deal with stress?

____
____

How do you typically deal with conflict?

____
____

How do you feel about structure and chores?

____
____

How do you feel about authority?

____
____

Emergency Contact:

Name: ____

Address: ____

Phone Number: ____

Relationship: ____

References:

Name: ____

Address: ____

Phone Number: ____

Relationship: ____