

DADC Intake Form

Client Number			Social Security Number				Date				
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
Client's Name (Last, First, Middle Initial)											
Street Address				City				State		Zip Code	
Client's Telephone Number Home:			Client's Date of Birth			If client is a minor, parent/legal guardian's name and SS#					
Cell:											
Contact Person – Last, First, Middle, Subtitle				Contact's mailing address:							
Contact's Telephone #:				Contact Relationship to Client: <input type="checkbox"/> Spouse <input type="checkbox"/> Friend <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other							
Intake Date:		Staff Number:		RU:		Staff Cost Center:					
Employer Phone #				Employer Name:				CARF Follow-up <input type="checkbox"/> Yes <input type="checkbox"/> No			
Entry Status Indicate the Client's current entry status with the agency. <input type="checkbox"/> First Entry <input type="checkbox"/> Re-Entry			Military Status: <input type="checkbox"/> Never Served <input type="checkbox"/> Veteran <input type="checkbox"/> On Active Duty <input type="checkbox"/> Reserves <input type="checkbox"/> Active Duty Dependent			Expected Primary Source of Payment for this Treatment: <input type="checkbox"/> Self Pay <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> Other Government Payment <input type="checkbox"/> Workers Compensation <input type="checkbox"/> Other Health Insurance <input type="checkbox"/> No Charge <input type="checkbox"/> Other			Number Of Household Members: (Include Client) Parenting Number of living minor children. Include step children, foster children, etc.		
Referral Source: What agency referred the client?			Client Living Arrangement: <input type="checkbox"/> Homeless <input type="checkbox"/> Dependent Living <input type="checkbox"/> Independent Living			Primary Source Of Income/Support: <input type="checkbox"/> Wage/Salary <input type="checkbox"/> Public Assistance <input type="checkbox"/> Retired/Pension <input type="checkbox"/> Disability <input type="checkbox"/> Other <input type="checkbox"/> None			How many minor children live with the client? Include all children, grandchildren, nephews, nieces, etc.		
Client's County Of Residence:			Employment: <input type="checkbox"/> Full Time (35 Hrs. +) <input type="checkbox"/> Part Time (less than 35 hrs) <input type="checkbox"/> Unemployed/Looking for work <input type="checkbox"/> Not in labor force			Income: what was the client's gross income during the last calendar month? Include all Sources.			Do any of your children have Medicaid that are currently in your custody? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Client's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			If not in labor force, indicate reason: <input type="checkbox"/> Homemaker <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Disabled <input type="checkbox"/> Inmate of Institution <input type="checkbox"/> Other			\$ What was the shared gross income of the household in which the client lived during the last calendar month? Include all Sources.			Is client pursuing custody of children not living with them? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Race Of Client: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other			How many months did the client work in the past 6 months?			\$ What was the shared gross income of the household in which the client lived during the last calendar month? Include all Sources.			Is the client pregnant. <input type="checkbox"/> Yes <input type="checkbox"/> No		
Ethnicity Of Client <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Mexican <input type="checkbox"/> Cuban <input type="checkbox"/> Other Hispanic <input type="checkbox"/> Not Of Hispanic Origin			Client Occupation:			Criminal Justice Related: Is the client's entry the result of arrest? <input type="checkbox"/> Yes <input type="checkbox"/> No			Indicate The Legal Circumstances Of The Client's Entry Into The Agency Program. (Check One) <input type="checkbox"/> DUI Relicensing Law <input type="checkbox"/> Provisional Driver's License <input type="checkbox"/> Pre-Trial <input type="checkbox"/> Pre-Sentence <input type="checkbox"/> Condition of Probation <input type="checkbox"/> Parole <input type="checkbox"/> Condition of Sentence <input type="checkbox"/> Juvenile Justice Diversion <input type="checkbox"/> None of the above		
Education: How many year's of formal education did the client complete?									Reason for referral: (ie. alcohol, marijuana, depression, emotional marital, behavior, etc.)		
Marital Status <input type="checkbox"/> Now Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Never Married											