



Intake Form

Date: _____

GENERAL INFORMATION

Reason for Visit: _____

Name: _____

First

Middle

Last

Gender: Male Female

Marital Status (circle one): Engaged Cohabiting Married

Single Separated Widowed Divorced

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Home Phone: _____

Cell Phone: _____ E-mail: _____

Church Affiliation: _____

Veteran: Yes No If Yes, details: _____

Homeless: Yes No If Yes, details: _____

What type of housing do you currently live in? (circle one)

House Apartment Friend/Relative Mobile Home Temporary

Homeless - Car Homeless - Street Homeless- Shelter Hotel/Motel

Subsidized Housing: Yes No If Yes, details: _____

If renting, Landlord Name _____ Phone No. _____

Justice System Involvement (circle all that apply): None Misdemeanor Felony

Referring Agency: _____

Referring Person: _____

Birthdate: _____ Driver's License #: _____

Primary Transportation: (circle one)

Auto/Truck Rides with Others Public Transportation Walk Bike

Soc. Sec. #: _____ Spouse: _____

How did your need arise? _____

How do you plan to be sustainable if you receive assistance? _____

EMPLOYMENT/EDUCATION/HEALTH INFORMATION

Employed: Yes No If Yes, Employer: _____

Employment Status (circle one): Part Time Full Time Temporary
Seasonal Unemployed Unable to Work Retired

Highest Level of Education: _____

How Long Employed? _____ Hourly Pay Rate: _____

Hours worked per week: _____ Weekly Take Home Pay: _____

Total Household Income _____ Circle One: Weekly Monthly

Ability to Work (circle one): Can Work - No Restrictions Can Work - Sheltered Setting
Can Work - Physical Limitation Work Restrictions Cannot Work

Disabilities: _____

Long-term Disabilities: Yes No

Primary Health Care Provider: _____

Health Care Insurance Company Name: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Phone Number: _____ Relationship: _____

HOUSEHOLD MEMBERS

of Adults in house: _____ # of Minors in house: _____

OTHER AGENCIES/MINISTRIES

Have you gone to other agencies or churches for help before coming to ATLAS? Yes No
If so, where? (Please list names of agencies & contact person at each agency)_____

Do you receive any public assistance? No Yes If yes, circle ALL that apply:

Food Assistance

WIC

SSI

Unemployment

SSDI

Cash Assistance

State Emergency Assistance

Do you have a CMH caseworker: No Yes If yes, name: _____

Do you have a DHHS caseworker: No Yes If yes, name: _____

MEDICAL INFORMATION

Overall Medical Condition (circle one): Healthy Acute mild/moderate

Acute severe

Chronic mild/moderate

Chronic severe

Diagnoses: _____

Are you on medications for (circle all that apply):

ADHD/ADD

Diabetes

Mood Regulation

Heart

Depression

Anxiety

Pain

Sleep

Other: _____

Do you have prescription medication that should be taken regularly? _____ No _____ Yes

If Yes, are you taking medications as prescribed? _____ Yes _____ No

If you are not taking medications as prescribed, please state why: _____

Have you ever applied for disability benefits? _____ No _____ Yes