

Contact Info

Today's Date:

Consumer Name: _____ Address: _____

Birth Name/Other Names: _____

Phone #: _____

Client ID# (Intake use only): _____ Social Security #: _____ - _____ - _____ Date of Birth: _____

Referral Information

Agency: _____

Contact: _____ Work Phone: _____

Why is this client being referred to Peoples Oakland? _____ Social Rehabilitation
_____ Bridging the Gap (Reentry Services)
_____ Vocational Rehabilitation

Treatment Team Information

Please identify members of this consumer's treatment team:

	Name	Agency	Phone
Psychiatrist:	_____	_____	_____
Therapist:	_____	_____	_____
Clinician:	_____	_____	_____
Service Coord:	_____	_____	_____
Other:	_____	_____	_____

Mental Health History

Primary Disability: ___Mental Health ___ Intellectual Disability ___ Drug ___ Alcohol Approximate Date of Onset:

Clinical Disorders (mental, personality, and developmental disorders)

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.

List Psychiatric hospitalizations over the last three years, starting with the most recent:

Hospital	From	To
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is this consumer's usual decompensation pattern?

Medical/Physical Health History

What physical health problems, if any, does this consumer have?

Medications

What, if any, are this consumer's current prescription medications? You may also attach an updated list of medications.

NAME	DOSAGE	FREQUENCY	NAME	DOSAGE	FREQUENCY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Is this consumer compliant with his/her current prescription medications? Yes _____ No _____

If not, please describe: _____

Substance Abuse

Date of onset of abuse problem: _____

Please list known substances of choice:

If this consumer is not currently abusing substances, please indicate date of last known use: _____

Is this consumer actively involved in AA? _____ NA? _____

Comments regarding past D/A treatment or rehab:

Housing

What is this consumer’s current living arrangement?

- Independent Living
- Facility-Based 24-Hour Care
- Criminal Detention
- Supervised or Supported Living
- No Permanent Home/Homeless
- Other

If not independent living, please provide the following information:

Facility Name:

Staff Contact:

Phone Number:

Behavioral

Does this consumer have a history of any of the following behaviors? If so, provide year of last incidence.

- Suicide Attempt (Year)
- Sexual Abuse/Assault (Year)
- Compulsive Behaviors [Lying, spending, etc.] (Year)
- Homicide Attempt (Year)
- Assault (Year)
- Drug/Alcohol Abuse (Year)
- Fire Setting (Year)
- Theft (Year)
- Other (Year)

(Behavior) Please provide details on treatment and/or legal outcomes subsequent to any of the above behaviors:

Behavioral

If this consumer is on probation or parole, please provide information:

	Name of Officer	Probation/Parole Agency	Phone
Probation:	_____	_____	_____
Parole:	_____	_____	_____

If this consumer is currently facing legal charges, please describe:

Vocational

OVR Counselor: _____ Phone #: _____

Is this consumer able to read and write at the adult level? Yes _____ No _____

How does this consumer's disability interfere with his/her ability to work?

Financial Information

Please list this consumer's monthly income by source:

Salary/Wages _____	SSDI _____	VA Benefits _____
Social Security _____	Pension _____	Other _____
SSI _____	Food Stamps _____	
Domiciliary Care _____	Public Assistance _____	

Describe any financial problems this consumer may be facing:

Please attach any documentation (medical records, psychological or vocational test results, etc.) pertinent to this consumer's medical, social, or legal history.

The staff of Peoples Oakland thank you for your help in providing this information.

RETURN TO:

Joel Heiney, Resource and Intake Coordinator

Peoples Oakland

3433 Bates Street

Pittsburgh, PA 15213

Phone: 412.683.7140 x236

Fax: 412.683.7138

Email: joelh@peoplesoakland.org