Contact Info

Today's Date:

Consumer Name: _____ Address: _____

Birth Name/Other Names: _____ _____

Phone #: _____

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

Referral Source Information

Agency: _____

Contact: _____ Work Phone: _____ Email: _____

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

Clinical Disorders (mental, personality, and developmental disorders; **please include F Codes**)

1.

2.

3.

4.

5.

6.

Approximate Date of Onset: _____

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

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 _____ SNAP _____

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, Programs Coordinator
Peoples Oakland
3433 Bates Street Pittsburgh, PA 15213

Phone: 412-683-7140 x 249
Fax: 412-683-7138
Email: joelh@peoplesoakland.org