DATE: _____ CREDIBLE #: _____

Northwestern
COMMUNITY SERVICES BOARD
A Behavioral Health Agency

ADULT SAME DAY ACCESS INTAKE FORM

Legal Name: _____ Preferred Name: _____ Date: _____

DOB: _____ SSN: _____ Birth Gender: ☐Male ☐Female

Email: _____ Gender Identity: _____

Race: _____ Hispanic Origin: _____ Preferred Language: _____

Street Address: _____ Cell Phone: _____

City, State, Zip: _____ Home Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

What brings you in today? _____

_____

_____

Requested Services: ☐ Psychiatry ☐ Case Management ☐ Substance Use ☐ Other: _____

Referred by: ☐ DSS ☐ Court ☐ ASAP ☐ Family/Friend ☐ Hospital ☐ Other/Relationship: _____

Employer: _____ ☐Full-Time ☐ Part-Time ☐ Not Employed

Education Level: ☐ High School Graduate/GED ☐Some College ☐ College Graduate ☐ Last Grade Completed: _____

Military Service: ☐ No ☐ Yes Branch: _____ Dates of Service: _____ to _____

Do you have dependent children: ☐ No ☐ Yes Ages: _____ Are you currently pregnant? ☐Yes ☐No

Primary Care Doctor: _____ # of ER Visits (last 6 months): _____
(NAME) (PRACTICE)

Have you recently been admitted to the hospital? ☐ No ☐ Yes: Name of Hospital: _____

Was your hospital stay ☐Psychiatric ☐ Medical Discharge Date: _____

LEGAL HISTORY:

Are you currently on Probation or Parole? ☐ No ☐ Yes Name of Probation or Parole Officer: _____

Have you been arrested in the last 30 days? ☐ No ☐ Yes Do you have access to weapons or firearms? ☐ No ☐ Yes

Current Legal Charges (Please List): _____

_____

CLIENT NAME: _____ CREDIBLE #: _____

Past Legal Convictions or Incarcerations (Please List):

PSYCHIATRIC SYMPTOMS/HISTORY:

Symptoms you are currently experiencing: _____

Have you ever, or are you currently receiving counseling, therapy, or seeing a psychiatrist for medication management? ☐No ☐Yes

If yes, please list current or most recent past providers below:

	Current:	Past:
Therapy/Counseling: _____	☐	☐
Psychiatrist/Practice: _____	☐	☐
Primary Care Treating: _____	☐	☐

Have you ever been psychiatrically hospitalized? ☐ No ☐ Yes If yes, how many times? _____

If yes, list last 3 psychiatric hospitalizations below:

Date	Hospital	Reason for Admission

SUBSTANCE USE HISTORY

Are you currently, or have you in the past, used, abused, or felt dependent on any substance?

Do you smoke cigarettes or vape nicotine? ☐ No ☐ Former Smoker ☐ Current Amount Per Day: _____

Have you ever participated in therapy, Detox, IOP, group, or Residential Treatment for substance use? ☐No ☐Yes

If yes, please list current or most recent past providers below:

Dates	Provider	Type of Treatment	Current	Past

Is there anything that you feel is important for us to know about your substance use history?

CLIENT NAME: _____ CREDIBLE #: _____

MEDICAL HISTORY

Current Prescribed Medications (Medical and Psychiatric)		
MEDICATION	**STRENGTH AND DOSAGE**	**PRESCRIBER**
☐ **ADDITIONAL MEDICATIONS LISTED ON THE BACK OF THIS PAGE**		

CURRENT MEDICAL ISSUES OR PHYSICAL COMPLAINTS:	

ALLERGIES TO FOODS, MEDICATION, OR OTHER:		

Is there anything else that you feel is important for us to know before we begin your assessment?