

**BRONX COMMUNITY SOLUTIONS**  
**Intake Assessment form**

Intake Date: --

**I. Court Information**

NYSID # \_\_\_\_\_ Docket # \_\_\_\_\_  
 Court Part \_\_\_\_\_ Jail Alternative \_\_\_\_\_  
 Defense Attorney: \_\_\_\_\_ ADA: \_\_\_\_\_  
 Contact Info: \_\_\_\_\_ Contact Info: \_\_\_\_\_  
 Probation  Parole

**II. Demographics**

Client's Name:   
 D.O.B.: --  
 SS#: --  
 Address:   
 Telephone: () -  
 Gender:  Male  Female  
 Race:  African American  Caucasian  Latino  
 Asian  Native American  Other, \_\_\_\_\_

Emergency Contact Name:  Relationship:   
 Address:   
 Telephone: () -

Forms of Identification on person:  
 Social Security Card  Birth Certificate  Driver's License  
 Medicaid Card  P.A. Card  Green Card

US Citizen  Yes  No Green Card #

**III. Alcohol/Substance Abuse History**

1. What drugs do you currently use?

Drug(s) of Choice*	Route**	Frequency	Amount	1 <sup>st</sup> Use	Last Use

\* Drug of Choice: (1) Alcohol, (2) Crack, (3) Cocaine, (4) Heroin, (5) PCP, (6) Street Methadone, (7) Marijuana, (8) Ecstasy, (9) Hallucinogens, (10) Inhalants, (11) Other...please specify.

\*\* Route of Administration: (1) Oral, (2) Nasal, (3) Smoking, (4) Non IV injection, (5) IV injection

2. Do you use more than one substance per day?  Yes  No  
 If Yes, what substances (use above codes)   
 3. At what age did you start using drugs?  age

DETOX

4. How many times have you been in Detox?

times

5. When was the last time (date) you were in Detox?

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6. What was the name of the last Detox program?

TREATMENT

7. Have you ever entered treatment for substance abuse?  Yes

No

If Yes, how many times have you entered treatment for drugs.

times

8. Are you currently in substance abuse treatment?

Yes

No

If Yes, Name:

Type:

Telephone Number:

Have you been in any other programs?

Yes

No

What are the names, type, and dates of the other programs:

Program 2: Name:

Dates:

Type:

Did you complete:  Yes

No, why didn't you complete?

Program 3: Name:

Dates:

Type:

Did you complete:  Yes

No, why didn't you complete?

Program 4: Name:

Dates:

Type:

Did you complete:  Yes

No, why didn't you complete?

**IV. Medical/Mental Health History**

9. Do you currently have any medical conditions or physical disability?

Yes

No

If Yes, which conditions do you have?

10. Are you currently taking any medication(s) for physical conditions?

Yes

No

If Yes, which medications for what conditions?

**When** was your last TB test?

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Positive

Negative

11. If female, are you currently pregnant?

Yes

No

12. Do you have any children?

Yes

No

If Yes, how many?

number

how many do you have custody of?

number

who has custody of any children that you don't have custody for?

13. Do you have a psychiatric or emotional problem?  Yes  No  
 14. Has anyone ever told you that you have a psychiatric/mental health diagnosis?  Yes  No

If Yes, what was the diagnosis?

15. Have you ever set any fires in the past?  Yes  No  
 16. Have you ever been convicted of a sex offense?  Yes  No  
 17. Have you ever committed a sex offense?  Yes  No  
 18. Have you ever thought about hurting yourself?  Yes  No  
 19. Have you ever thought about killing yourself?  Yes  No  
 20. Have you ever thought about killing someone else?  Yes  No  
 21. Have you ever physically hurt someone else?  Yes  No  
 22. Have you ever heard any sounds or voices that other people could not hear?  Yes  No  
 23. Have you ever seen things that other people cannot see?  Yes  No

24. Have you ever been hospitalized for any mental health reason?  Yes  No

If Yes, were these hospitalizations:  
 Inpatient hospitalizations  Yes  No  
 Psychiatric Emergency Room (ER) visits  Yes  No  
 Both  Yes  No

Which hospitals, if known?

25. Are you **currently** taking any medications for any mental health reason?  Yes  No

If Yes, which medications for what conditions.

26. Have you taken any medications in the **past** for psychiatric/mental health problems?  Yes  No

If Yes, what?

27. Are you currently in psychiatric/mental health treatment now? (check all that apply)  
 None  Outpatient clinic  
 Day treatment  Residential  
 Jail Medication/counseling  Other, \_\_\_\_\_

Where, if known?

28. Have you received psychiatric treatment in the past?  Yes  No  
 If Yes, what? (check all that apply)  
 None  Outpatient clinic

- Day treatment                       Residential  
 Jail Medication/counseling       Other, \_\_\_\_\_

**V. Entitlements/Benefits**

29. Do you receive?

- Public Assistance                       Food Stamps                       Medicaid  
 SSI/SSD                                       Unemployment                       Medicare  
 Social Security                               Veterans Assistance                       Retirement/Pension  
 Private Insurance                               None

Medicaid Status       Active       Inactive  
 Medicaid Number: \_\_\_\_\_

Have you ever served in the Military?       Yes  No  
 If Yes, what branch, years and Type of discharge?  
 \_\_\_\_\_

**VI. Employment/Educational History**

30. Are you employed?       Yes       No  
 If Yes, what is your position: \_\_\_\_\_  
 Is it:       Full-time or  Part-time  
 Address: \_\_\_\_\_  
 Telephone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_

31. Are you a student       Yes       No  
 If Yes, name of school: \_\_\_\_\_  
 Are you:       Full-time or  Part-time

If No, do you have a high school diploma?       Yes       No  
 Do you have a GED?       Yes       No  
 What grade completed? \_\_\_\_\_

**VI. Services needed**

32. What services are needed? (check all that apply)
- Housing (temporary or permanent)
  - Detox
  - Rehab
  - Residential treatment (long or short term)
  - Counseling- Psychiatric
  - Health Care, what \_\_\_\_\_
  - Employment Services
  - Entitlement Assistance
  - Other, what \_\_\_\_\_

Recommendation	
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