VOCA GRANT FAMILY AND MEDICAL FORM

DO NOT leave any portion blank – If something does not apply, please write N/A

Client Name: ____ Date of Birth ____ /____ /____

□ Male S.S. # ______-____-________

Address: ____________________________________ □Home Phone: _________________________________

____ □Work Phone: __________________________________

____ □Cell Phone: ___________________________________

Email: ____

Please check the phone number that should be used by the office staff for scheduling purposes

Status: Married In domestic partnership Divorced Separated Never married Spouse/partner deceased

Race: White African American American Indian/Alaska Native Asian Hispanic/Latino Native Hawaiian Other

Military Status: Veteran Active Duty N/A

LGBTQ Status (self-identify as): Heterosexual Homosexual Transvestite Other______________

Deaf/Hard of Hearing: Yes No

Disability (physical or cognitive) Yes (please define)_____________________________________ No

Currently Homeless: Yes No

Immigrant: Yes No Primary Language _______________________________

Have you experienced the following: Physical Abuse Mental Abuse Verbal/Mental Abuse Sexual Abuse

Employer: ____ Occupation: ____________________________________

Name, Age and Relationship of all individuals residing within your home (including parents or caretakers)

Name	Age	Relationship to Client

If known:

Primary Care Physician (PCP) _______________________________ Medical Practice _________________________________

Address_____________________________________ City ____________________________ State _____ ZIP ______________

Phone#: ___________________________ Fax#: __________________________ Date of Last PCP Visit: ___________________

Allergies, medical conditions, disabilities ____

List all of your medications (office will copy personal list)

Name of Medication	Current Dosage/Frequency	Start Date of Medication

Name(s) of prescribing doctor(s): ____________________________________

Emergency Contact (please list an individual to contact if we cannot reach you)

Contact Person ___________________________ Home _______________________ Work/Cell_______________________

VOCA Grant Intake Information

DO NOT leave any portion blank – write-in or check N/A where applicable

List any professionals or agencies that have been involved with your mental health treatment ☐ N/A

Type of Service	Name of Professional / Agency	Approximate Dates of Service

FAMILY HISTORY

Psychological / psychiatric treatment: ☐ N/A

PERSON PROBLEM DATES PROVIDER OUTCOME

____

____

Psychiatric hospitalizations: ☐ N/A

PERSON REASON FOR HOSPITALIZATION LENGTH OF STAY TREATING PHYSICIAN

____

____

Medical problems and/or physical disabilities: ☐ N/A

PERSON PHYSICAL PROBLEM / DISABILITY TREATING PHYSICIAN

____

____

Please initial all applicable problems that your extended family has experienced using the corresponding initials in the key below:

(M=Mother, F=Father, C=Child, SB=Sibling, G=Grandparent, A=Aunt, U=Uncle ,S=Self)

___ Alcohol	___ Family Problems	___ Depression	___ Parenting
___ Family Violence	___ Financial Difficulties	___ Physical Health	___ Work-Related Stress
___ Legal Difficulties	___ Mood Swings	___ Emotional	___ Anxiety
___ Drug Addiction	___ Marital Relationship	___ Interpersonal Problems	___ Eating Disorder
___ Bi-Polar	___ ADD/ADHD	___ Career Issues	

Do we have your permission to acknowledge to your physician your involvement in counseling? **YES** **NO**

____ _____________________

Signature of Client Date

I give my permission for the office staff to contact me at the phone numbers/e-mail that I provided on this intake form and to leave messages regarding appointments, etc. Courtesy reminder calls/e-mails are available upon request. However, I understand that this service is a courtesy and scheduled appointments are the responsibility of me, the client.

____ ____________________

Signature of Client Date