



Intake Form

Date: _____ Referred By: _____

Name: _____

Phone Number: _____

Email: _____ Religious Affiliation: _____

Where are you currently staying? City?: _____

Birthdate: _____ Age: _____

Place of Birth: _____ Citizenship: _____

Race: _____ Social Security Number: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Engaged ___ Separated

Do you own a car? ___ Yes ___ No In your name? ___ Yes ___ No Is it paid off? ___ Yes ___ No

Do you have a valid Driver's License? ___ Yes ___ No Do you have car insurance? ___ Yes ___ No

Section 1

- 1) Are you currently pregnant? Yes No
- 2) How many weeks pregnant are you? _____
- 3) What is your expected due date? _____
- 4) What was the date of your last prenatal doctor visit? _____
- 5) Doctor's Name: _____
- 6) Doctor's Phone Number: _____
- 7) How are you feeling about your pregnancy?

- 8) Are you having a boy or a girl? _____

Section 2

1) Are you receiving WIC at this time? Yes No

2) Are you on any type of government assistance? Yes No

If you answered yes, please list which ones.

3) Do you have insurance?

() Medicaid

() Medicare

() Private

() Medical Assistance

() VA

() None

() Other : _____

Section 3

1) Do you have any of the following?

Mental Health Issues Yes No Explain: _____

Drug Issues Yes No Explain: _____

Alcohol Issues Yes No Explain: _____

Asthma Yes No Explain: _____

Diabetes Yes No Explain: _____

Allergies Yes No Explain: _____

Developmental Disability Yes No Explain: _____

Physical Disability Yes No Explain: _____

HIV/AIDS Yes No Explain: _____

- Victim of Domestic Violence Yes No Explain: _____
- Chronically Mentally Ill Yes No Explain: _____
- Special Needs Yes No Explain: _____
- Unspecified Disability Yes No Explain: _____
- Communicable Illness Yes No Explain: _____
- Tuberculosis Yes No Explain: _____
- Learning Disability Yes No Explain: _____
- Lupus Yes No Explain: _____
- Attention Deficit Disorder Yes No Explain: _____

1) Are you on medication? Yes No

If yes, please list and explain:

2) Do you have any other health problems? Yes No

If yes, please explain:

3) Are there any emotional problems in your family? Yes No

If yes, please explain:

4) History of drug or alcohol abuse in your family? Yes No

If yes, please explain:

5) Have you used:

Alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	First Time _____	Last Time _____
Marijuana	<input type="checkbox"/> Yes	<input type="checkbox"/> No	First Time _____	Last Time _____
Cocaine/Crack	<input type="checkbox"/> Yes	<input type="checkbox"/> No	First Time _____	Last Time _____
Heroin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	First Time _____	Last Time _____
Meth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	First Time _____	Last Time _____
Prescription Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	First Time _____	Last Time _____
Pain Killers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	First Time _____	Last Time _____

6) Do you smoke? Yes No

Section 4

Your Mother's Name: _____

Whereabouts: _____

Your Father's Name: _____

Whereabouts: _____

What is your relationship like with your family?

Do you know who the father is? Yes No

Baby's Father's Name: _____

Whereabouts: _____

How did you meet? _____

How long have you known him? _____

What do you like about him? _____

Can you describe his personality? _____

Does he know you are pregnant? Yes No

How does he feel about it? _____

Does he have a history of drug use? Yes No

Have you used drugs together? Yes No

Does he own a weapon? Yes No

Has he threatened you? Yes No

Has he threatened others? Yes No

What is your relationship like with your baby's father?

Section 5

Have you been pregnant before? Yes No If yes, how many times? _____

Do you have any children? Yes No

Please list all of your children's names:

Child's First Name: _____ Last Name: _____

Age: _____ Date of Birth: _____ Gender: _____

Child's Father's Name: _____

Who has legal custody? _____

Child's First Name: _____ Last Name: _____

Age: _____ Date of Birth: _____ Gender: _____

Child's Father's Name: _____

Who has legal custody? _____

Child's First Name: _____ Last Name: _____

Age: _____ Date of Birth: _____ Gender: _____

Child's Father's Name: _____

Who has legal custody? _____

Child's First Name: _____ Last Name: _____

Age: _____ Date of Birth: _____ Gender: _____

Child's Father's Name: _____

Who has legal custody? _____

Section 6

Have you experienced physical, emotional, or verbal abuse? (Please Explain)

Have you experienced sexual abuse? (Please Explain)

Is your family aware of this? _____

Have you ever sought counseling? _____

Are you in danger? _____ By Whom? _____

Section 7

Are you currently under court authority, including DFS, for any reason? Yes No

If yes, explain:

Are you on probation or parole? Yes No

If yes, explain:

Do you have any pending charges? Yes No

If yes, explain:

Do you have any prior convictions? Yes No

If yes, explain:

Do you acknowledge that we will run a background check before you are accepted into Lori's House? Yes No

Signature: _____ Date: _____

Section 8

Who might visit you while you are here?

How will this program help you?

What are your views on God?

How do you deal with stress?

How do you typically deal with conflict?

How do you feel about structure and chores?

How do you feel about authority?

Emergency Contact:

Name: _____

Address: _____

Phone Number: _____

Relationship: _____

References:

Name: _____

Address: _____

Phone Number: _____

Relationship: _____