eliminating racism
empowering women
ywca
Northeast Indiana

YWCA IS ON A MISSION

5920 Decatur Road
Fort Wayne, IN 46816
(260)424-4908 Fax: (260)420-5202
www.ywca.org/NEIN

Hope House

HOPE HOUSE INTAKE ASSESSMENT

☐ IN PERSON ☐ TELEPHONE ☐ MAIL ☐ FAX ☐ ONLINE

Date _____ Completed By _____

Name _____ SSN _____ DOB _____

Age _____ Current Marital Status ☐ Single (Never Married) ☐ Married ☐ Divorced _____

Are you currently in Fort Wayne? ☐ Yes ☐ No, I am in _____

Housing Status ☐ Homeless: Currently living _____

☐ Homeless Shelter ☐ Transitional Living Facility

☐ Eviction (with no resources for housing) ☐ Discharged from other facility (with no housing available)

☐ Other _____ Type of facility _____

Length of stay _____

How did you hear about Hope House? _____

List your children by age and their living situation.

_____ _____ _____ _____

_____ _____ _____ _____

Family Physician _____

If you do not have a family physician, where do you go for medical care? _____

Medical Problems _____

Mental Health Care Providers (ex. Psychiatrist, Counselor, Therapist)

Name _____ Location and Phone # _____

Name _____ Location and Phone # _____

Do you have a psychiatric diagnosis? ☐ Yes ☐ No

If yes, please list what, when, and by whom (ex. PTSD, 2006, Dr. Smith at Mental Health, Inc.).

_____ _____

Medications

Name & Reason _____ Name & Reason _____

Name & Reason _____ Name & Reason _____

Name & Reason _____ Name & Reason _____

Employment Status

☐ Employed Place of employment _____

☐ Unemployed Date and place of last employment _____ **SSI** ☐ **SSDI** ☐

Please list any current or pending legal issues/charges.

_____

_____

Are you currently on probation/parole? ☐ No ☐ Yes

United Way

List the name and number of your PO, CM, and/or attorney. _____

May Hope House contact this person? ☐ Yes ☐ No

Have you previously had and/or are you currently receiving treatment for either substance abuse or mental health?

FACILITY	THERAPIST/CASEWORKER	LEVEL OF CARE	DATES
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please indicate if you have ever used any of the following substances.

☐ Alcohol ☐ Opiates (ex. heroin) ☐ Cannabis ☐ Cocaine ☐ Stimulants

☐ Prescription Meds ☐ Sedatives / Depressants ☐ Methamphetamine ☐ Hallucinogens ☐ Other _____

List the top three substances that you are currently (or recently) having problems with.

SUBSTANCE	AGE OF FIRST USE	FREQUENCY OF USE	DATE OF LAST USE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

When was your last period of sobriety? _____

When and for how long was your longest period of being clean? _____

Do you have a history of seizures, blackouts, DT's, or withdrawal? ☐ No ☐ Yes

Indicate if you have any of the following withdrawal symptoms.

☐ Seizures* ☐ Delirium Tremens (DT's)* ☐ High Blood Pressure* ☐ Hallucinations*

☐ Nausea/Vomiting ☐ Tremors/Shakes ☐ Fever/Chills ☐ Diarrhea

☐ Cramps ☐ Eating Disorders ☐ Irritability ☐ Aggression

☐ Weakness * Must have a medical release if indicated.

Are you having any suicidal ideation or threats? ☐ Yes ☐ No

If yes, is there a specific plan and what? _____

Do you have a support network family and/or friends? ☐ No ☐ Yes

If yes, list the person closest to you (name, relationship, length known). _____

May Hope House contact this person? ☐ Yes ☐ No Phone # _____

What is your reason for seeking treatment at Hope House?

_____

_____

Please list a phone number where you can be contacted. _____

Please fax completed application to 260.420.5202, attention Hope House.

HOPE HOUSE STAFF ONLY

FOLLOW-UP DATES & COMMENTS _____

_____