INTAKE ADMISSION DATA - IN HOME FAMILY TREATMENT CLIENTS ONLY (2006)

1025-1252007 INTAKE ADMISSION DATA IN HOME FAMILY TREATMENT CLIENTS ONLY – pen (sc 1_27_2007).doc

Instructions

1. Complete all fields for In Home Family Treatment Clients upon admission. Send completed form to the TxMS Data Entry Department at the Community Mental Health Center of Crawford County.

Date of Admission Interview ______ ***Center Case # (Data Entry)*** ______ ***Date Case Was Opened (Data Entry)*** ______

Client's Name: ______ Last ______ First ______ MI

Alternate Name: ☐ Alias ☐ Other ☐ Premarital Name ☐ Not Applicable

______ Last ______ First ______ MI

SS Number: ______ - ______ - ______

Gender: ☐ Female ☐ Male ☐ Transgender - F to M ☐ Transgender - M to F

DOB: ______ ***Hispanic:*** ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Home Address: ______

______

City, State, Zip: ______

Resident County: ______ ***Responsible County:*** ______

Phone(s): ______ Home ______ Work ______ Other Phone & Type

Ethnicity (check all that apply and circle primary):

☐ American Indian or Alaskan Native
☐ Asian
☐ Black/African American not of Hispanic Origin
☐ Native Hawaiian/Other Pacific Islander
☐ Other/Unknown
☐ White

Annual Gross Income: $ ______

Program Initially Referred to

Admission Status (Registration): ☐ Not Enrolled ☐ Pending

Initial Service Provided: ______

# of units of service provided: ______ ***Date:*** ______

Acuity:
☐ Emergency (circumstances require that the assessment be completed within 3 hrs)
☐ Urgent (assessment to be completed within 72 hrs)
☐ Routine Appointments (assessment to be offered within 10 working days of initial contact, treatment to begin within 10 working days of the assessment)

Admission Date: ______ **Closing Date:** ______

COMPLETE DIAGNOSIS INFORMATION ON BACK

DIAGNOSIS

- Always indicate the **Primary Diagnosis.**
- Include all 5 Axes if possible. **Axes 1, 2, and 5 are required**.

Axis	***DSM-IV Code and Description***
________	________________________________
________	________________________________
________	________________________________
________	________________________________
________	________________________________
________	________________________________
________	________________________________
________	________________________________
________	________________________________

***Axis IV Type*:**

- ☐ Economic Problem
- ☐ Educational Problem
- ☐ Health Care Services Access Problem
- ☐ Housing Problem
- ☐ Legal System Interaction Problem
- ☐ Occupational Problem
- ☐ Other Psychological or Environmental Problem
- ☐ Primary Support Group Problem
- ☐ Social Environment Problem

***Axis IV Memo*:**

Axis V ***GAF:*** ________ ***GARF:*** ________ ***SOFAS:*** ________ ***CGAS:*** ________

Dual Diagnosis: ☐ Yes ☐ No

Has the client received services here before? ☐ Yes ☐ No ***If yes, when?*** ____________________

Does the client have a Medical Card from the SRS? ☐ Yes ☐ No

Medical Card #: ____________________

ADAS Client? ☐ Yes ☐ No ***Insurance?*** ☐ Yes ☐ No

Referring Agency: ______________________________

Screener's/Admission Counselor's Name: ______________________________

Signature: ______________________________