Buffalo Trace Medical Arts
A Division of Comprehend, Inc.

CLIENT INTAKE FORM

Admission Date _____ SSN _____ Avatar ID_____

Last Name	**First**	**Middle**		**Age**	**Date of Birth**
Street	**City**	**State**	**Zip**	**Home Phone**	
Alt. Phone	**Parent/Guardian Name**			**School**	

Marital Status: Single Married Divorced Co-Habitating Widow Separated Sex: Male Female DSS: Yes No

Family Size (number of household members dependent on income): _____ **State Guardianship**: Yes No **Veteran**: Yes No

Race ◯White/Caucasian ◯Black/African American ◯Asian ◯American Indian/Alaskan Native ◯Hawaiian/Pacific Islander

Hispanic Origin: Not Hispanic Puerto Rican Mexican Cuban Other Hispanic Education (last grade completed) _____

Employer Name/Address: **WK Phone**: ( ) -

If not employed are you interested in employment? Yes◯ No◯

Any Arrests in the Last 30 Days: Yes◯ No◉

Primary Language: ENG ASL SPA CHI JPM FRE GER ITA KOR NAI RUS THA VIE Other: _____

Employment Status: _____

01 – Employed Fulltime
02 – Employed Part-Time
03 - Laid off from job
04 – Looking for work
05 – In the armed forces
06 – Homemaker
07 – Student (age 6 or older)
08 – Retired
09 – Resident of Institution
10 – Child (preschool/age 5 or under)
11 - Disabled

Total Gross Family Income:
$_____
(reported to IRS)

Primary Source of Income:___

1 – Wages/salary/self employed
2 – Public Assistance
3 – Retirement/Pension
4 – Disability
5 – Other Sources
6 – No Income/Support

Family Size: _____

Living Arrangements: _____

01-Homeless**
02-Mission/Shelter
03-Hotel/Motel
11-Staffed Residence
12-Alcohol/Drug Facility
21-Living in parent's home
22-Living in own residence
23-Living in own residence with parent or guardian
24-Boarding Home
25-Family Member
26-Friend
31-Nursing Home (SNF)
32-Personal Care Home
33-ICF/MR State Facility
34-ICF/MR Private Facility
35-Family care home
41-Foster care
42-Jail/prison (local/state)
43-Jail/prison (federal)

SSI or SSDI or TANF: _____

0-No receives none
1-Yes-SSI Only
2-Yes-SSDI Only
3-Yes-Both SSI and SSDI
4-Yes-TANF only
5-Yes-SSDI and TANF

County of Residence: _____

012-Bracken
035-Fleming
068-Lewis
081-Mason
101-Robertson
103-Rowan
233-OH
240-TNA
246-WA
Other: _____

School Attendance in the Last 90 Days

0 – No
1 – No because school/college is on break
2 – Yes – Public, Private, Home School, College or University
3 – Yes – Self Contained Special Ed. who are not main streamed

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Primary Source of Referral: _____ Secondary Source of Referral: _____

01 –Self	14-Probation/Parole	23-SA Treatment Facility (State)	34-DDS (DCBS; CPS)
02-Employer	15-Other Legal Entity	24-SA Treatment Facility (Private)	35-Other Social Services Agency
03-Family/Friend	16-DUI/DWI	25-SNF/ICF/MR Facility (State)	36-Health Department
04-Self Help Group	17-Other Criminal Justice	26-SNF/ICF/MR Facility (Private)	37-DSI
05-Clergy	18-Diversionary Program	27-Personal Care Home	41-Private Psychiatrist
11-Police	19-DJJ	28-General Hospital	42-Private Psychiatric Office
12-State/Federal Court	20-Drug Court	31-School/Family Resource	43-Physcian
13-Formal/Adjudication	21-State Funded Psychiatric Hosp.	32-Voc Rehabilitation	44-Private Therapist
	22-Other Psychiatric Hosp.	33-Communoity MH/MR Center	45-Other

Is it OK to leave a message at Home / Alt. Phone Number? Yes ○ No ○ At Work? Yes ○ No ◉

Emergency Contact: _____ Relationship _____ Phone _____

Previous MH/MR Treatment: _____ Previous Hospitalizations: _____

Family Physician/Address/Phone: _____

_____

Do you have a living will? Yes ○ No ○

To my knowledge the above information is accurate and I hereby give my permission to the Staff of Comprehend Regional Mental Health and Mental Retardation Board, Inc. to render treatment and services.

I also authorize Comprehend Inc. to release to my insurance company and medical or psychiatric information that may be required to process my claim with my primary or secondary insurance.

I understand that my insurance claims cannot be processed without this release. I further understand that I may be billed at a future date for any services not covered by my policy. I agree to pay for any services not covered by my policy, based on Comprehend's sliding fee scale.

I hereby authorize and instruct my insurance company to make any benefits payable to Comprehend Inc.

_____

Signature of Client/Representative Relationship to Client Date

I have read, or had read to me, and I have been provided with a copy of Comprehend's Notice of Privacy Practices and Client Right's as defined by the Health Insurance Portability and Accountability Act of 1996.

_____

Signature of Client/Representative Relationship to Client Date

_____

Signature of Staff Date

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