

**Illinois Department of Veterans' Affairs
Prince Homeless and Disabled Program
One Veterans Drive
Manteno, Illinois 60950
(815) 468-6583
(815)-468-9965 fax**

Intake Form

Date:	
Full Name:	Birthdate:
Contract/Referral Person:	Phone: ()
Contact Address:	

Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN:	Marital Status:
Highest Level of Education: <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> GED <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18		
Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicaid #:	Medicare #:

Referral Source: Put an X in the Box that applies to your referral.	
<input type="checkbox"/>	Self Referral
<input type="checkbox"/>	Veteran Assistance Commission (Name/town):
<input type="checkbox"/>	P.A.D.S. (Indicate town):
<input type="checkbox"/>	Shelter Program (Name/town):
<input type="checkbox"/>	VA Hospital (Name/Program):
<input type="checkbox"/>	Other (please list):

Military Service:			
Branch of Service:		Discharge Type:	
Enlistment Date:	Discharge Date:	Copy of 214: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Served in Combat: <input type="checkbox"/> Yes <input type="checkbox"/> No	Wounded/Injured: <input type="checkbox"/> Yes <input type="checkbox"/> No	Served under fire: <input type="checkbox"/> Yes <input type="checkbox"/> No	

Employment History				
Current Employment Status:	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Full Time	<input type="checkbox"/> Part Time	<input type="checkbox"/> Temporary
Current or most recent position held, include dates and reason for leaving:				
What is the longest period of time you have been able to hold a job?				
Do you plan to actively seek employment?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have vocational training? Please explain:			<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Do you have college credits?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any certifications or training in a specific type of job? If YES, please, indicate:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a current resume? If YES, please attach to intake packet	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Housing History:				
Where have you slept most frequently within the last year?				
<input type="checkbox"/> Shelters:	<input type="checkbox"/> Transitional Housing:	<input type="checkbox"/> Safe Haven(safe place to sleep):	<input type="checkbox"/> Outdoors:	<input type="checkbox"/> Other:
Have you been homeless within the last three years?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Finances:				
Current course of income? Put an X in the box that applies to your income source.				
<input type="checkbox"/>	None			
<input type="checkbox"/>	Employment			
<input type="checkbox"/>	Veteran Benefits	<input type="checkbox"/> Service Connected	<input type="checkbox"/> Non-Service Connected	
<input type="checkbox"/>	Social Security Insurance (SSI)			
<input type="checkbox"/>	Social Security Disability Insurance (SSDI)			
<input type="checkbox"/>	Unemployment Insurance			
Monthly income range? Put an X in the box that applies to your income range.				
<input type="checkbox"/>	None			
<input type="checkbox"/>	\$ 100.00 - \$ 250.00			
<input type="checkbox"/>	\$ 251.00 - \$ 500.00			
<input type="checkbox"/>	\$ 501.00 - \$1,000.00			
<input type="checkbox"/>	\$1001.00 - \$1,500.00			
Do you currently have a checking account?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you currently have a savings account?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
I understand that by my signature, I am verifying the information in the entire intake packet is true and accurate. I understand that misrepresentation, falsification or material omissions of information or data during the intake				

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process or while at the Illinois Department of Veterans' Affairs Prince Homeless and Disabled Program may result in my not being admitted to the Prince Program, or, if admitted, may result in my being discharged from the Prince Program. I understand that I am liable for any damages I cause to Prince property or equipment and failure to make restitution will result in Major warning(s). I also understand that I have the right to use the agency grievance process at any time during my service experience with the Prince Program.

I understand that if I am accepted as a resident of the Prince Program I will be restricted from taking an overnight pass for a minimum of 30 (thirty) days. Further I understand I will be on probation for 30 days.

Applicant's Signature:

Date:

Witness Signature:

Date:

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MEDICAL HISTORY/EMERGENCY DATA

Full Name:		Date:
DOB:	SSN	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of last Tetanus shot?		
Date of last TB Test?	Results of TB Test? (Positive or Negative)	
Have you ever had any serious accident or illnesses in the past? If yes, please explain:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any limitation of mobility or physical restrictions? If yes, please explain:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any allergies or known adverse drug reactions? If yes, please explain:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have current medications you are taking or that have been prescribed, but you do not take? If yes, please explain:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any ongoing physical health problems? If yes, please explain:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have dentures? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you wear glasses/contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use a hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have any artificial limbs? <input type="checkbox"/> Yes <input type="checkbox"/> No
PHYSICIAN	PSYCHIATRIST	EMERGENCY CONTACT
Name:	Name:	Name:
Address:	Address:	Address:
		Relationship:
Date:	Date:	Date:
If hospitalized, do you want your emergency contact to be notified?		<input type="checkbox"/> Yes <input type="checkbox"/> No

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SOCIAL HISTORY

Full Name:		Date:
DOB:	SSN:	Primary Language:

Family of Origin		
Father:		Birthdate:
Mother:		Birthdate:
Parents marital status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
Describe our relationship with your Father:		
Describe our relationship with your Mother:		
# of siblings:	# of sisters:	# of brothers:
Name:	Birthdate:	
Name:	Birthdate:	
Name:	Birthdate:	
Name:	Birthdate:	
Name:	Birthdate:	
Describe your relationship with your siblings:		

Childhood		
Where were you born?	Where did you grow up?	
How would you describe your childhood?		
Do you recall any abuse when you were a child? If yes, by whom and what type of abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you receive any therapy (for any reason) while you were a child?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there any history of addiction in your family of origin? If yes, who was addicted and what were they addicted to?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you recall any significant loss, either through death, divorce or other means? If yes, can you recall what impact this had on you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
As a youth, did you have any involvement with the law? If yes, please explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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SOCIAL HISTORY
(Continued)

Describe your experience during your military career. Include the reasons for joining and reasons for getting out, positive and negative experiences, and the ways you have changed because of your military experience, what you learned in the military, and awards you earned.

This must be completed

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SOCIAL HISTORY
 (Continued)

Family of Creation

What is your current marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed		
If married, were any children born?		<input type="checkbox"/> Yes <input type="checkbox"/> No
# of children:	# of daughters:	# of sons:
Name:		Birthdate:
Name:		Birthdate:
Name:		Birthdate:
Describe your relationship with each of your children:		
Have you had any other significant relationships?		<input type="checkbox"/> Yes <input type="checkbox"/> No
How long were you in this relationship?		
Were any children born?		<input type="checkbox"/> Yes <input type="checkbox"/> No
# of children:	# of daughters:	# of sons:
Name:		Birthdate:
Name:		Birthdate:
Name:		Birthdate:
Describe your relationship with each of your children:		

Legal

Have you ever been convicted of a crime? (Not including minor traffic offenses) If Yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently on probation/parole or supervision? If Yes, please explain, include the name of your supervising officer:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any outstanding fines, warrants or pending court dates? If Yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any child support orders that are current or delinquent? If Yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been convicted for a Felony charge? If Yes, please explain:	<input type="checkbox"/> Yes <input type="checkbox"/> No

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MENTAL HEALTH HISTORY

Name:	Date:	
1. Have you ever participated in counseling in the past? If Yes, when, where, how long:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Are you currently in counseling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Psychiatrist <input type="checkbox"/> Psychologist <input type="checkbox"/> Substance Abuse Counselor <input type="checkbox"/> Therapist/Counselor		
Counselor's Name:		
Location:		
3. Are you currently taking any psychotropic medications? If Yes, please list:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. As an adult, have you ever felt suicidal or contemplated suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you ever made an attempt to commit suicide? If Yes, please describe the circumstances:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Are you suicidal at this time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Do you have a plan for how to kill yourself? If Yes, what is your plan:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Are you planning to kill yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Can you promise that you will not try to kill or hurt yourself or anyone else while at the Prince Program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Are you feeling depressed at this time to an extent that you are unable to function normally?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Have you recently or ever stopped eating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Have you had trouble sleeping recently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Do you feel anxious?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Do you feel unable to leave the house, to go about your normal business?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Do you have any other emotional problems that have not been mentioned? If Yes, please explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Have you ever had a panic/anxiety attack? When:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Have you ever been diagnosed with PTSD?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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MENTAL HEALTH HISTORY
(Continued)

When:		
18. Have you ever been diagnosed with depression? When?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. Do you have nightmares?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. Do you have a family history of mental illness? If Yes, please explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21. If you have psychotropic medications, do you take them as prescribed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
22. Have you ever been hospitalized for mental health reasons? If Yes, please explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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SUBSTANCE ABUSE PROFILE

Name:		Date:	
Read each question carefully		Check the correct response	
1. Is the use of alcohol/drugs a part of your life? Check: <input type="checkbox"/> alcohol <input type="checkbox"/> drugs <input type="checkbox"/> both		<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever tried to control or stop your use?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Is the use of alcohol/drugs a part of your daily routine?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you ever felt guilty as a result of your drinking/drug use?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Have you ever used alcohol or drugs to help you sleep, relax or relieve stress?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Do you feel you re a normal drinker?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you ever drank or used drugs more than you planned?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have you ever awakened after drinking or using drugs and found that you could not remember part of the previous 24 hours?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have friends or family expressed concerns about your drinking/drug use?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Have you ever been arrested as a result of drinking/drug use?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Have you ever been in any accidents where alcohol/drugs were involved?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Have you ever attended an AA, NA, Al-Anon or Alateen meeting?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Did anyone in your family have problems with alcohol? If Yes, which family members:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Have you ever been concerned about a family member's drinking or drug usage? If Yes, which family members:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Do you find your moods changing as a direct result of your drinking/drug use?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Are you currently in a substance abuse treatment program? If Yes, please give the time period when involved in treatment:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. How long have you been in recovery:			
18. Do you maintain success over substance abuse by participating in a support group?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
19. Have you ever had a DUI conviction? How many? Please explain:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
20. Have you ever been in jail or placed on probation because of alcohol/drugs? If Yes, please explain:		<input type="checkbox"/> Yes	<input type="checkbox"/> No

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SUBSTANCE ABUSE PROFILE
(Continued)

21. Are you currently on a waiting list for a substance abuse treatment program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
22. Can you stop drinking without a struggle in 1 or 2 drinks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23. Do you try to limit your drinking to certain times of the day or to certain places?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
24. Are you always able to stop drinking when you want to?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
25. Have you gotten into fights when drinking or using drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
26. Have you ever lost a significant other because of alcohol/drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
27. Have you ever gotten into trouble at work because of alcohol/drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
28. Have you ever lost a job because of alcohol/drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
29. Have you ever neglected your family or your job for more than two days in a row because you were drinking or using drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
30. Do you ever drink or use drugs before noon?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
31. Have you ever been told you have liver problems? <input type="checkbox"/> Cirrhosis? <input type="checkbox"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
32. Have you ever had Delirium Tremors (DTs), severe shaking, heard voices or seen things others cannot after drinking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
33. Have you ever gone to anyone for help about your drinking/drug use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
34. Have you ever been hospitalized because of alcohol/drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
35. Have you ever been a patient in a psychiatric hospital or on a psychiatric unit where alcohol/drugs were part of the problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
36. On the average, how many days a week do you drink alcohol and/or use drugs? (1-7 days)		
37. When you drink, on the average, how many drinks do you have? (one drink = 1 beer = 1 glass wine = 1 shot of hard liquor = 1 oz of alcohol)		
38. Have you ever been treated for alcoholism?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
39. How concerned are you about your current relationship with alcohol or drugs? <input type="checkbox"/> 1. Not concerned at all. <input type="checkbox"/> 4. Concerned. <input type="checkbox"/> 2. Not concerned, but I'm careful. <input type="checkbox"/> 5. Very concerned. <input type="checkbox"/> 3. A little concerned. <input type="checkbox"/> 6. I want help.		
40. Have you ever participated in a detox program? <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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SUBSTANCE ABUSE PROFILE

(Continued)

41. # of detox/rehab treatment programs: <i>(Check one)</i> <input type="checkbox"/> none <input type="checkbox"/> 1-3 <input type="checkbox"/> 3-5 <input type="checkbox"/> 5-7 <input type="checkbox"/> more than 7		
42. Most recent detox/rehab treatment program: <i>(Check one)</i> <input type="checkbox"/> Current <input type="checkbox"/> 1-6 mos <input type="checkbox"/> 6-12 mos <input type="checkbox"/> 1-3 yrs <input type="checkbox"/> 3-5 yrs <input type="checkbox"/> 5-10 yrs <input type="checkbox"/> 10+ yrs		
43. Location of most recent program:		
44. Last known date of alcohol/drug use:		
45. Drug(s) of choice: 1) 2) 3)		
46. Method of use: <input type="checkbox"/> drinking <input type="checkbox"/> snorting <input type="checkbox"/> smoking <input type="checkbox"/> intravenous		
47. Do you currently attend AA/NA meetings? # per week:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
48. Have you been clean and sober for the past 30 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
49. Do you feel that your use of alcohol and/or other drugs has impacted your ability to relate to others around you or to maintain steady housing and employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
50. Do you feel that you have any issues with your use of alcohol and/or other drugs of abuse to the extent that you continue to use them regardless of the consequences?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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RELEASE OF INFORMATION**

I, _____, _____, hereby authorized

to release information to the Illinois Department of Veterans' Affairs Prince Homeless and Disabled Program pertaining to my:

- All and any . _____ Initial

- Medication List. . _____ Initial

- Medical records including TB results, HIV results, and Immunization dates. . _____ Initial

- Laboratory reports, including blood test, drug/alcohol screenings. _____ Initial

- Medical and Clinical progress notes. _____ Initial

- Bio/Psycho/Social reports. _____ Initial

- Admission and Discharge summary reports. _____ Initial

- Other: _____ . _____ Initial

for the purpose of continuity of care, assessment, case planning, and case management.

I understand that the authorization shall remain valid from the date of my signature below and one year thereafter ending on: _____.

I have been informed that I may revoke this authorization by written or oral communication to the Prince Homeless and Disabled Program. I certify that this form as been fully explained to me and that I understand its contents.

Signature of Veteran

Date of Authorization

Signature of Witness of Signature

Date

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RELEASE OF INFORMATION**

I, _____, _____, hereby authorized the Illinois Department of Veterans' Affairs Prince Homeless and Disabled Program to release information to

pertaining to my:

- All and any. _____ Initial
- Medication List. _____ Initial
- Medical records including TB results, HIV results, and Immunization dates. _____ Initial
- Laboratory reports, including blood test, drug/alcohol screenings. _____ Initial
- Medical and Clinical progress notes. _____ Initial
- Bio/Psycho/Social reports. _____ Initial
- Admission and Discharge summary reports. _____ Initial
- Other: _____ . _____ Initial

for the purpose of assessment and delivery of services.

I understand that the authorization shall remain valid from the date of my signature below and one year thereafter ending on:_____.

I have been informed that I may revoke this authorization by written or oral communication to the Prince Homeless and Disabled Program. I certify that this form as been fully explained to me and that I understand its contents.

Signature of Veteran

Date of Authorization

Signature of Witness of Signature

Date

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APPLICANT INTAKE STATUS
OFFICE USE ONLY

Name:	I.D.:
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Date Application Sent Out:	Contact Method:
Date Application Received:	Date Supporting Documents Received:
Interview Date:	Interview Results:

Date of Acceptance Letter:	Contact Method:
Date of Decline Letter:	Contact Method:
Reason for declining applicant:	

Needed Services:		
<input type="checkbox"/> Individual Therapy	<input type="checkbox"/> Group Therapy	<input type="checkbox"/> PTSD Therapy
<input type="checkbox"/> Alcohol Treatment	<input type="checkbox"/> Drug Treatment	<input type="checkbox"/> Resume Writing Group
<input type="checkbox"/> Therapy for Depression	<input type="checkbox"/> Therapy for Anxiety	<input type="checkbox"/> Anger Management
Notes:		

Missing Information From Submitted Intake Form By Section:

Referral Source Contact Date (Final Decision):	
<input type="checkbox"/> Letter	<input type="checkbox"/> Call

Admission Date:	
Staff:	Date:
Staff:	Date:
Staff:	Date:
Program Director:	Date: