Client Intake

The F8 Foundation

Date___/___/_____

720 Ralph McGill Blvd. NE, Suite 330
Atlanta, GA 30312

_______________ _______________ ___ ____/____/______ ______-______-________
Last First MI Birth Date Social Security #

Gender: ___ M ___ F Age: _____ Marital Status: ___ Single/NM ___ Sep/Div ___ Widow/er Race: ______________

Address ____________________________________ Cell Phone ( ) _______ - ________

Mailing Address (if different) ______________________________ Email ________________

Pregnant ___ Y ___ N ____ # of Children DCF Involvement ___ Y ___ N Explain: ________________

____

____

With whom do you reside? ______________________________ # of months / years at residence: __________

Is your address permanent: ___ Y ___ N If temporary, until what date: ____________

Where was your last residence? ___ Parent/Guardian ___ Friend/Relative ___ Independent (House/Apartment)

___ Treatment Facility (Detox / Rehabilitation / Transitional-Holding / Half-Way House)

Name of treatment center: ____________________________ In / Out Dates: ______________

___ Correctional Institution State: ____ County: ____ In/Out dates: ____________

___ Homeless Where homeless: ____________________________ Length of Time: __________

___ Other Please describe: ______________________________________

Are you a United States Citizen: ___ Y ___ N If no, Country of Origin: ____________________

Are you a United States Veteran: ___ Y ___ N If yes, Which military branch? ________________

Primary Language: ___ English ___ Spanish ___ Other (____________) Read & Write English? ___ Y ___ N

Secondary Language: __________________ Read & Write Spanish? ___ Y ___ N Need Interpreter? ___ Y ___ N

Do you consider yourself? spiritual___ religious___ Name of Religion: ____________________

Any religious restrictions: ____

Documents to obtain: ___ Birth Certificate ___ SS Card ___ Driver's License ___ Other Photo ID ___ Library Card

EDUCATION Highest Level of Education Completed: ___ Less than High School ___ Diploma/GED
___ Some College ___ Trade/Professional Certification ___ Associate's Degree ___ Bachelor's Degree
___ Some Graduate ___ Master's Degree Subject / Area of Study: ____________________

School	Location	Dates Attended	Graduate Y / N

Cynthia@thef8foundation.org (857) 488-6506

Client Name: ______________________ **Date:** ____/____/______

Employment

Have you ever been employed? ___ Y ___ N **Currently employed?** ___ Y ___ N

Company	Location	Job Title	Dates Worked

Work Skills / Experience: ____

____

Short-Term Employment Goals: ____

Long-Term Employment Goals: ____

Please list any Professional References: 1. ______________________________

2. ______________________________ **3.** ______________________________

Sources of Income

_____ None _____ Wages/Salary _____ Alimony _____ Child Support _____ Disability – SSI _____ Disability – SSDI

_____ Veterans Disability Payment _____ Private Disability Payment _____ Public Assistance - General

_____ Public Assistance – TANF _____ Unemployment Compensation _____ Workers Compensation

_____ Retirement - Social Security _____ Retirement/Pension - Private _____ Veterans Pension

Monthly Food Stamps $ ____________ Total Monthly Income from above: $______________

Contract cell phone? ___ Y ___ N If yes, monthly cost: $ ______________

Health Insurance

Primary Care Provider (PCP): ____________________ PCP #: ( ) _____-_______

Medical Conditions? (i.e., Diabetes, High Blood Pressure, Hep-C): ______________________________

Do you have health insurance? ___ Y ___ N Do you have more than one health insurance? ___ Y ___ N

_____ **Uninsured** _____ **MC** (Medicaid / MassHealth / MBHP) ____ **MP** (Medicare –Over 65 /disabled)

_____ **VA** (Veterans Administration) _____ **HM** –(HMO) (Private HMO – through employment or client pay)

_____ **CI** (Private Insurance – through employment or client pay with no subsidy)

_____ **OT** (Other - Includes State subsidy – Connect Care / Health Safety Net)

Insurance ID #: ______________________ Insurance ID #: ______________________

Emergency Contacts **(at least one person)**

Name: ______________________________ Name: ______________________________

Relation:____________ Cell # ( ) _____-_______ Relation: ____________ Cell # ( ) _____-_______

Client Name: ____________________________ **Date:** ____/____/______

Legal History

Are you currently on: Probation ___ Parole ___ End date: ___/___/______

Probation / Parole Officer: ______________________________ Phone # ( ) ______ - ________

If yes, nature & disposition of offense(s): Last Wrap Date: ____/____/________

Any current restrictions: ____

Any Pending Case(s): ___Y ___N If yes, please describe: ____________________________

# of times in jail/prison as an adult: ______ Total time incarcerated as an adult: ________

Please list all convictions past ten years: ______________________________________

Convicted of sex offenses: _____ yes _____ no If yes, describe nature & disposition of offense(s), name of victim, & any current restrictions: ____

Convicted of arson offenses: _____ yes _____ no If yes, describe nature & disposition of offense(s), location of crime, & any current restrictions: ____

Any current restraining orders issued against you: _____ yes ____ no If yes, please describe by naming the complainant, the court, date 209A issued, expected termination date: ______________________________

Any current restraining orders issued against another individual: ____ yes ____ no If yes, please describe by naming your assailant, the court, date 209A issued, expected termination date: ______________________________

I, ____________________________, state that the aforementioned legal history is true and accurate to the best of my ability. I authorize The F8 Foundation to verify any or all of the above legal history. I understand that The F8 Foundations reserves the right to terminate my participation in the program if The F8 Foundation determines the information provided to be knowingly false.

Client signature: ________________________________ Date: ____/____/________

The F8 Foundation
Client Intake
Client Name: ______________________ **Date:** ____/____/______

Mental Health

Are you currently taking prescription medications? ☐ Yes ☐ No

Medication	Dosage/Frequency	Medication	Dosage/Frequency

# of times in the following: ____ Counseling ____ Crisis-Stabilization ____ Dual-Diagnosis Units ____ Hospitalization

Have you previously been diagnosed with a mental illness? ___ Y ___ N If yes, what was the diagnosis & when was it diagnosed? (Please list if more than one.) ____

____

Last five hospitalizations w/ dates. 1. ____________________ 2. ____________________

3. ____________________ 4. ____________________ 5. ____________________

Are you experiencing medication side effects? ___ Y ___ N If yes, please explain what they are & how you cope with them. ____

____

Which of the following symptoms have you experienced over the past month? For each symptom, indicate how distressed you have felt by it, using the following scale:

1 = "not at all," 2 = "a little," 3 = "somewhat," 4 = "quite a bit," 5 = "extremely."

		Yes / No	Severity
1.	Depression (sadness, feeling blue, low self-esteem)	______	______
2.	Anxiety (worry, fear, panic attacks)	______	______
3.	Sleep problems (falling asleep, awakenings, nightmares, too much)	______	______
4.	Anger (irritability, outbursts)	______	______
5.	Cognitive problems (poor attention, memory problems)	______	______
6.	Apathy / anhedonia (not caring about anything, difficulty initiating action, lack of pleasure)	______	______
7.	Hallucinations (hearing or seeing things others don't)	______	______
8.	Delusions (unusual thoughts or ideas)	______	______
9.	Other symptoms (specify: ____________________)	______	______

The F8 Foundation
Client Intake
Client Name: ______________________________

Date: _____/_____/________

Substance Abuse

_____ # of days clean & sober _____ # of months clean & sober Date of last drink or drug-use? ____/____/________

_____ # of Detoxes _____ # of Section 35 _____ # of CSS / TSS _____ # of Half-way Houses _____ # of sober-houses

_____ # of homelessness past 2 years Currently Homeless ___ Y ___ N Currently living w/ Family / Friend ___ Y ___ N

1st Substance of Abuse ___ Alcohol ___ Marijuana ___ Cocaine / Stimulants ___ Heroin / Opiates ___ Pills ___ Other

2nd Substance of Abuse ___ Alcohol ___ Marijuana ___ Cocaine / Stimulants ___ Heroin / Opiates ___ Pills ___ Other

3rd Substance of Abuse ___ Alcohol ___ Marijuana ___ Cocaine / Stimulants ___ Heroin / Opiates ___ Pills ___ Other

Client believes they are alcoholic / drug-addict. ___ Y ___ N Client reports problems due to gambling. ___ Y ___ N

Client reports IV drug-use. ___ Y ___ N _____ # of overdoses past 12 months _____ # of overdoses past 12 – 24 months

Do you consider yourself an alcoholic? ___ Y ___ N Do you consider yourself a drug addict? ___ Y ___ N

Do you believe you can continue using substances safely? ___ Y ___ N Gambling Problems? ___ Y ___ N

Do you believe you can continue using substances w/out legal consequences? ___ Y ___ N

Would you agree with the following? "I need help to live an alcohol and drug-free lifestyle." ___ Y ___ N
If no, why not? ____

Which of the following is true about alcohol / drugs for you?

Using alcohol / drugs…	Not True	Sometimes True	Often True
• Is important to socializing with friends	_____	_____	_____
• Helps me meet and get to know people.	_____	_____	_____
• Lowers my anxiety when w/ people.	_____	_____	_____
• Makes me feel less depressed.	_____	_____	_____
• Makes me feel less anxious.	_____	_____	_____
• Helps me forget my problems.	_____	_____	_____
• Helps me sleep better.	_____	_____	_____
• Helps reduce boredom.	_____	_____	_____
• Is an important source of pleasure.	_____	_____	_____
• Gives me something to look forward to.	_____	_____	_____
• Is one of the only things that makes me feel good.	_____	_____	_____
• Is chiefly a habit.	_____	_____	_____

Are you familiar with the 12-Steps (i.e., Alcoholics Anonymous, Narcotics Anonymous)? ___ Y ___ N

Can you envision yourself living alcohol & drug free? ___ Y ___ N If yes, what would your life look like? If no, why not? ____

____

Client Name: ______________________________ **Date:** ____/____/_______

Request & Authorization to Participate in The F8 Foundation

I, ____________________________, voluntarily completed The F8 Foundation Intake Interview. I also state the aforementioned information is true and accurate to the best of my ability. I understand that participation in The F8 Foundation (F8) program is above and beyond my compliance with the rules of any residential treatment facility I am in now, or any residential treatment facility in the future. I understand that if I am not in compliance with program rules, F8 reserves the right to terminate my participation with the F8. I must be committed to attend sessions on a consistent basis in order to receive the greatest benefit from the program. Although I may self-terminate my participation at any time, I agree to inform F8 of my decision prior to my last visit. If the F8 believes that I can receive more effective treatment elsewhere, I will be given referrals. I understand that I may not attend a session if I am under the influence or possession of alcohol or drugs, unless otherwise prescribed by a physician. I understand that I may not attend a session if I am in possession of a dangerous weapon.

______________________________	______________________________	____/____/_______
F8 Client Print Name	**F8 Client Signature**	**Date**
______________________________	______________________________	____/____/_______
F8 Counselor Print Name	**F8 Counselor Signature**	**Date**

I, ____________________________, have received, read, and understand The F8 Foundation Informed Consent and Limitations to Disclosure Agreement. I hereby release The F8 Foundation and its employees from all legal responsibilities or liability that may arise from the use or disclosure of listed records and other information in reliance on this authorization.

____ I hereby release and indemnify The F8 Foundation and its employees from legal responsibility and liability that may arise during transportation (i.e. motor vehicle accident) to and from any legal or court proceedings, as well as any clinical activity in the treatment continuum.

____ I understand that I may refuse to sign this authorization and that The F8 Foundation may not condition treatment on whether I sign this authorization. I have the right to stop the use or release of information at any time, although I understand that The F8 Foundation cannot control handling of disclosed information to an approved agency or individual after it has been disclosed by this authorization.

______________________________	______________________________	____/____/_______
F8 Client Print Name	**Client Signature**	**Date**
______________________________	______________________________	____/____/_______
F8 Counselor Print Name	**F8 Counselor Signature**	**Date**

The F8 Foundation
Po Box 185
Westborough, MA 01581

Cynthia Kussy-Goldberg
Cynthia@thef8foundation.org
(857) 488-6506

Authorization to Obtain / Disclose Information

I, ____________________________, authorize The F8 Foundation to obtain or disclose legal and health-related information in accordance with the Health Information Protection and Portability Act (HIPPA), and other state or federal laws concerning attorney-client privilege, probate and family, and the privacy of health information. The authorization applies to myself, The F8 Foundation, and the following agency &/or person: ____.

Purpose of Authorization to Obtain or Disclose Information

___ Coordination of Care & Case Management ___ At the Request of the Client.

___ Treatment Planning & Follow-up ___ Appeal / Grievance Resolution

___ Response to HHS or government agency ___ Response: Court Order or Subpoena

___ Assessing Compliance (breathalyzer / urinalysis) ____ Other:________________________.

___ Assessing Legal Status (i.e. criminal, civil and/or probate and family).

Information to Which the Authorization Applies

___ All Clinical Information ___ All Progress Notes

___ Medical Information Only ___ Psychiatric Information Only

___ List of Current / Past Medications ___ Incident Reports

___ Discharge / Termination Summary ___ Dates of Service (_______ to _______)

___ Appeal, Grievance & Review Information ___ Other: ____________________________.

___ Legal Activity: Criminal Court ________________ Probation/ Parole ___ Civil Court ___

___ Legal Activity: Probate & Family Court ______________________________________.

Exceptions to Authorization

____

____

I state this authorization is signed by me voluntarily. It may be withdrawn by me at any time. I may withdraw this authorization verbally and in writing. This authorization expires upon termination of my F8 participation.

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Authorization to Obtain / Disclose Information

____________________________ ____________
F8 Client Signature **Date**

____________________________ ____________
F8 Counselor Signature **Date**

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___ Medical Information Only ___ Psychiatric Information Only
___ List of Current / Past Medications ___ Incident Reports
___ Discharge / Termination Summary ___ Dates of Service (_______ to _______)
___ Appeal, Grievance & Review Information ___ Other: ______________________.
___ Legal Activity: Criminal Court ______________ Probation/ Parole ___ Civil Court ___
___ Legal Activity: Probate & Family Court ______________________________________.

Exceptions to Authorization

____
____

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Authorization to Obtain / Disclose Information

F8 Client Signature ______________________ **Date** __________

F8 Counselor Signature ______________________ **Date** __________

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Informed Consent For Services & Limitations Of Confidential Communications

I, ____________________________, herby request that I be accepted for services by The F8 Foundation (F8). I give my authorization for F8 to work in conjunction with the residential treatment program that I am currently residing in or any residential program in the future, provided such treatment program allows for my participation with F8. I understand that F8 is ***not*** a licensed outpatient alcohol and drug treatment program. F8 provides services for Re-Entry Counseling, Full-Life Recovery and Career Development, at no charge or cost to me. However, in accordance with the Health Information Protection and Portability Act (HIPPA) and other state and federal laws, confidential communications between me and F8 may be revealed without my consent or permission under the following circumstances:

1. If necessary to protect my safety or the safety of others.

   a. If I am clearly dangerous to myself, my F8 Counselor may take steps to seek involuntary hospitalization. My F8 Counselor may also contact members of my family or others if necessary to protect my safety.

   b. If I threaten to kill or seriously hurt someone and my F8 Counselor believes I may carry out my threat, or if I have a known history of physical violence and my F8 Counselor believes I will attempt to kill or seriously hurt someone, my F8 Counselor may:
      - Tell any reasonably identified victim(s);
      - Notify the police; or
      - Arrange for me to be hospitalized.

2. If a judge thinks the F8 Counselor has important evidence about my ability to provide suitable care or custody in a child custody or adoption case.

3. In court proceedings involving the care and protection of children or to dispense with the need for parental consent to adoption.

4. If the F8 Counselor believes a child, a handicapped person, or an elderly person in my care is suffering injury as a result of abuse or neglect.

5. To provide information regarding my diagnosis, prognosis and course of treatment to an insurance company, HMO or governmental agency paying for these services.

6. In a legal proceeding where I introduce my mental or emotional condition or, in the event of my death, in a proceeding where my mental or emotional condition is introduced.

7. If I bring an action against the F8 Counselor and disclosure is necessary or relevant to a defense.

8. If necessary to use a collection agency or other process to collect amounts I owe for services.

9. If a court orders access to my records (a “bishop order”) in a sexual assault or other criminal case.

I also authorize my F8 Counselor to discuss my treatment with colleagues or consult with other treating professional to enhance services I receive from The F8 Foundation. I have had the opportunity to discuss this informed consent with my F8 Counselor. I understand its meaning and consent to receiving F8 services based on this understanding.

F8 Client Signature: ______________________________ **Date:** ______________

F8 Counselor Signature: ______________________________ **Date:** ______________

The F8 Foundation
P.O. Box 185
Westborough, MA 01581
www.thef8foundation.org
857-488-6506

RELEASE AND AUTHORIZATION TO SPEAK TO LEGAL REPRESENTATIVE AND OR ATTORNEY

I, ____________________, give Cynthia Goldberg, Director of the F8 Foundation, permission to discuss my legal case with the following Attorney:_________________________________

Cynthia has my full authorization to discuss, review legal documents, court documents, medical reports and any other report pertaining to myself, and share pertinent information with my attorney.

I give full permission to reach me via the F8 foundation's email: Cynthia@thef8foundation.org and communicate via the F8's telephone at 857-488-6508

Respectfully yours,

____

Date