



ADULT INTAKE DATA

Date of Assessment: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Safe to send mail? Yes No Alternate address: _____

Home Phone: (_____) - _____ Safe to leave message? Yes No

Cell Phone: (_____) - _____ Safe to leave message? Yes No

Email Address: _____ Safe to leave message? Yes No

Have you received services at Safe Connections before? Yes No

Did you use another name? Yes No If so, Name: _____

The mission of Safe Connections is to reduce the impact and incidence of relationship violence and sexual assault through education, crisis intervention, counseling and support services. *We do not discriminate on the basis of race, color, sex, citizenship status, national origin, ancestry, gender, sexual orientation, gender identity, gender expression, age, religion, creed, physical or mental disability, marital status, veteran status, political affiliation, or any other factor protected by law.*

I request that Safe Connections consider my application for service.

Signed _____ Date _____

INFORMATION ABOUT YOU

The information on this page is requested so that this organization may demonstrate its compliance with the requirements of its funding agencies including the United Way. Choosing not to respond to some of the questions on this page will not affect your application for services.

Birth Date: ____/____/____ **Age:** _____

Race /Ethnic Background:

- African American/ Black
- Asian/ South Asian
- Bi-Racial /Multi-Racial
- White/ Caucasian
- Hispanic/Latina or Latino
- American Indian/ Alaska Native
- Middle Eastern/ Arab
- Native Hawaiian/ Pacific Islander
- _____

- Married
- Divorce in Process
- Divorced or Annulled
- Widowed
- Not currently in a relationship
- Unsure of relationship status
- Other

Current Employment Status:

- Unemployed (with work history)
- Unemployed (with no work history)
- Employed

If employed, what is your occupation?

Sexual Orientation:

- Asexual
- Bisexual
- Straight/Heterosexual
- Lesbian/Gay
- Pansexual
- Queer
- Prefer not to Disclose
- _____

Last Grade Completed:

- 8th Grade or less
- Some High School
- High School Graduate
- GED Diploma
- Vocational/Tech School
- Some College
- Bachelor Degree
- Some Graduate School
- Graduate Degree
- Other Post Graduate Work

Gender:

- Woman/ Girl
- Trans Identified
- Man/ Boy
- Non-Binary/Genderqueer
- _____

Pronouns: _____
(Ex: She/Her/Hers)

What is your current household income?

- \$0-\$9,999
- \$10,000-\$14,999
- \$15,000-\$19,999
- \$20,000-\$29,999
- \$30,000-\$49,999
- \$50,000-\$99,999
- More than \$100,000
- Unknown

Relationship Status: Are you currently (as of today)

- In a relationship
Partner(s) Gender or Pronouns: _____
- Married
Partner(s) Gender or Pronouns: _____
- Married and Separated

Number in household: _____

Referred to Safe Connections from:

- | | |
|--|--|
| <input type="checkbox"/> Friends/Family | <input type="checkbox"/> Hospital/E.R. |
| <input type="checkbox"/> Other Counseling Agency | <input type="checkbox"/> Employer |
| <input type="checkbox"/> Private Therapist | <input type="checkbox"/> EAP |
| <input type="checkbox"/> Telephone Directory | <input type="checkbox"/> Religious Community |
| <input type="checkbox"/> Schools: Project HART | <input type="checkbox"/> Safe Connections Helpline |
| <input type="checkbox"/> Schools: Colleges | <input type="checkbox"/> Other Hotline |
| <input type="checkbox"/> Schools | <input type="checkbox"/> Billboards |
| <input type="checkbox"/> Lawyer | <input type="checkbox"/> Shelter |
| <input type="checkbox"/> Courts | <input type="checkbox"/> Substance Abuse Program |
| <input type="checkbox"/> Police | <input type="checkbox"/> Media/Public Service Announcement |
| <input type="checkbox"/> Doctor | <input type="checkbox"/> Own Previous Agency Contact |
| | <input type="checkbox"/> Other |

Are you mandated to receive services? ____Yes____ No

If yes, by whom?

Check one and fill in name: ____ Children's Division – Case manager's Name: _____

____ Probation/Parole – Officer's Name: _____

Reason mandated: _____

CURRENT STRESSORS: (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Loss/Lack of support system (family or friends) | <input type="checkbox"/> Homelessness |
| <input type="checkbox"/> Current safety issues | <input type="checkbox"/> Employment issues |
| <input type="checkbox"/> Relationship issues | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Other: _____ |

In order to better serve you, do you have any special needs that we should be aware of?

Any cultural considerations?

COUNSELING/MENTAL HEALTH HISTORY

Have you ever been in the care of a psychiatrist? ___Yes ___No

If yes:

Who _____

When _____

Have you ever been hospitalized due to your mental health? ___Yes ___No

If yes:

How many times? _____

Most recent _____

Where _____

When _____

Reason _____

Do you take prescription medications (for medical and/or psychiatric reasons)? ___Yes ___No

If yes:

Please list current medications _____

How long have you taken these medications? _____

Do you take it: ___ As prescribed
 ___ Less than prescribed
 ___ More than prescribed

Have you ever had suicidal thoughts? ___Yes ___No

Have you ever attempted suicide? ___Yes ___No

If yes:

How many times? _____

Most recent _____

When _____

Method _____

Are you currently suicidal?

___Yes ___No

If yes:

Do you have a plan? Explain _____

Do you have the means available? _____

Is there anyone you could turn to for support? _____

Have you ever received any kind of counseling/therapy?

_____Yes _____No

If yes:

At what age did you first seek therapy? _____

How many prior counselors/therapists have you seen? _____

Name of most recent Counselor/Therapist and Facility _____

When? _____ How long? _____Years _____Months

What was the motivation for the **above** counseling or therapy? (*check all that apply*)

_____ Domestic Violence

_____ Sexual Abuse

_____ Economic Problems

_____ Emotional Abuse

_____ Family Problems

_____ Substance Abuse

_____ Required by Probation /Parole

_____ Legal Problems

_____ Relationship Issues

_____ Psychological Problems

_____ Personal Growth

_____ Other personal difficulties

_____ Sexual/Gender Identity

What kind of counseling /therapy services did you receive? (*check all that apply*)

_____ Individual Counseling /Therapy

_____ Peer Support Group

_____ Couples Counseling

_____ Family Counseling

Have you **ABUSED** alcohol and/or drugs in the past? _____Yes _____No

If yes:

What have you used? _____

Within the **past 2 weeks**, have you **used** any alcohol and/or drugs? ___Yes ___No

If yes, what have you used? _____

Have you ever been in a detox or rehab program? ___Yes ___No

If yes, number of times: _____

Name of program/center: _____

Do you drink/use drugs to be accepted by partner? _____Yes _____No

Do you drink/use drugs to relieve stress at home? _____Yes _____No