Attachment

SOCIAL INTAKE FORM

I. DEMOGRAPHIC INFORMATION

Name: ____ SSN: ____________________________

Address: ______________________________________ DOE: ____________________________

City: ____ DOB: _________________ Age: _______

State: _____________ Zip Code: _________________ Phone #: (   ) ___________________

II. FAMILY BACKGROUND

Mother/Guardian: ____________________________ Father/Guardian: _________________________

Address: ____________________________________ Address: _______________________________

City: ____ City: __________________________________

State: ______________ Zip Code: _______________ State: ______________ Zip Code: ____________

Phone #: (   ) ______________________________ Phone #: (   ) ___________________________

Siblings: Yes ________ No ________ If yes, how many: ________

Children: Yes ________ No ________ If yes, how many: ________

Name: ______________________ Age: ______ Name: _____________________________ Age: _______

Name :______________________ Age: ______ Name: _____________________________ Age: _______

Has the Job Corps child allotment been explained to you? Yes________ No________

Who is the day care provider for your child(ren)? ____

Who raised you? ____

Whom have you lived with for the past year? ____

How long have you lived there? ______________________ Do you like living there? ________________

If a minor, do you live with your parent? Yes________ No________

If no, the reason is: ____

Do you have a caseworker? Yes________ No________

If yes, caseworker's name is: ___________________________________ Phone #: (   ) ______________

Describe your relationship with the following people (e.g., excellent, good, fair, poor, none):

Mother/guardian: ____

Father/guardian: ____

Siblings: ____

Significant other/spouse: ____

Friends: ____

Others (e.g., teachers, bosses, etc.): ____

III. LEGAL ISSUES

Have you even been in trouble with the police? Yes _______ No _______
If yes, for: ____

Are you presently awaiting charges, court, or sentencing? Yes _______ No _______
If yes, for: ____

Are you currently on probation? Yes _______ No _______
If yes, probation officer's name: _________________________________ Phone #: ( ) ____________
Address: ____
City: ____________________________________ State: ______________ Zip Code: _______________

IV. EDUCATIONAL BACKGROUND

Did you receive any special education or resource classes? Yes _______ No _______
If yes, in what areas? ____

Why did you leave school? ____

Were you ever suspended or expelled? Yes _______ No ______
If yes, how many times and reason(s): ____

V. WELLNESS SUPPORT

Job Corps wants to support you in your career progression. Often, personal issues can interfere with your career progression. Job Corps offers a full program of support. **Information will be confidential and shared only with staff/agencies with a need to know, as required by Job Corps or community laws.**

Have you ever been in counseling before? Yes _____ No _____ Was it helpful? Yes _____ No _____

_____ Depression (feeling sad, hopeless, crying, sleep or appetite problems, low energy, withdrawn)
Previous treatment/counseling at ____________________________________ Date: __________

_____ Auditory or visual hallucinations (hearing voices or seeing things)

_____ Suicide thoughts _____ Gesture(s) _____ Attempt(s) _____
When? ____________________________ Plan: ____
Previous treatment/counseling at ____________________________________ Date: __________

_____ Anger issues (easily irritated, bad temper, violent outbursts, punches people/things)

_____ Anxiety (feeling stressed out, fearful, panics, always worried)

_____ Poor self-esteem (feeling worthless, cannot do anything right, puts self down)

_____ Sexual abuse (rape, incest, molestation) When (age): _______________
Previous treatment/counseling at ____________________________________ Date: __________

_____ Physical abuse (hit by family member, significant other)

_____ Relationship issues Family _____ Partner _____ Friends _____ Gang _____
Substance use of family or partner _____

_____ Grief issues (dealing with the loss of family or friend)

_____ Parenting issues (overwhelmed by child-rearing responsibility, fearful of abusing child)

_____ Attention deficit hyperactivity disorder (trouble concentrating, over-energized, cannot complete tasks)

VI. WELLNESS ALCOHOL AND DRUG USE INVENTORY

I understand this information is confidential and will only be shared with Job Corps staff with a need to know.

Have you ever experimented with or used alcohol or other drugs? Yes _____ No _____

Please provide your age when you first used and how many times you have used in the past 30 days:

Substance Used	Age Started	Frequency of Use	# of Times Used in Last 30 Days
Alcohol			
Alcohol to point of intoxication (drunk)			
Cigarettes or chewing tobacco			
Marijuana (maryjane, bud, chronic, hydro)			
Cocaine (coke)			
Crack			
Amphetamines (meth, speed, tweek, glass, crank)			
PCP (sherm, angel dust)			
LSD (acid)			
Heroin or opium			
Ecstasy (E, X, XTC)			
Barbiturates, benzos (Klonopin, Ativan, Valium) or other sedatives (somas)			
Methadone			
Opiates (codeine, morphine, percocet)			
Inhalants (paint, glue, gas, whippets, etc.)			
Polydrug use (more than one at a time)			

Have you ever used a needle to shoot any of these drugs? Yes_____ No_____

Do you worry about how substance use may affect your future or health? Yes_____ No_____

Have you ever tried to stop using all substances? Yes_____ No_____

If Yes:

Why did you stop?____

When did you stop and for how long?____

Reasons for restarting:____

In your lifetime, how many times have you experienced the following because of your substance abuse:

Experience	# of Times	Comments
Lost time or forgot about events when drinking		
Had the shakes after drinking		
Overdosed on drugs		
Been arrested for possession of alcohol, DUI, or public intoxication		
Been arrested for possession of drugs or paraphernalia		
Lost a job		
Lost friends or partners		
Accidental injury (cut self, fracture, sprain)		
Arguments or fights over your use		

Have you ever been treated for alcohol or drug abuse? Yes_____ No_____

If yes: Where:____ Date:__________________

Do you feel that any family members, your partner, or friends have problems with drugs or alcohol that affects you? Yes_____ No_____

DO YOU WANT ASSISTANCE IN DEALING WITH ANY OF THESE ISSUES?

Yes _____ No (but I understand that I may seek help at any time) _____

Student Signature ____ Date ______/______/______

Staff Signature ____ Date ______/______/______

Reviewed by:

Counseling Manager: ____ Date______/______/______

Center Mental Health Consultant**:** ________________________________Date_____/_____/______

ITEMS FOR INTERVENTION PLAN:

_______ **TEAP REFERRAL**

_______ **MENTAL HEALTH REFERRAL** **Assigned to:** ________________________________

_______ **SPECIAL GROUPS** **Group(s):** ___________________________________

COMMENTS REGARDING STUDENT'S MOTIVATION AND NEEDS: