

INTAKE ADMISSION DATA - IN HOME FAMILY TREATMENT CLIENTS ONLY (2006)

1025-1252007 INTAKE ADMISSION DATA IN HOME FAMILY TREATMENT CLIENTS ONLY - pen (sc 1\_27\_2007).doc

Instructions

1. Complete all fields for In Home Family Treatment Clients upon admission. Send completed form to the TxMS Data Entry Department at the Community Mental Health Center of Crawford County.

Date of Admission Interview Center Case # (Data Entry) Date Case Was Opened (Data Entry)

Client's Name: Last First MI

Alternate Name: Alias Other Premarital Name Not Applicable Last First MI

SS Number: - -

Gender: Female Male Transgender - F to M Transgender - M to F

DOB: Hispanic: Hispanic or Latino Not Hispanic or Latino

Home Address:

City, State, Zip:

Resident County: Responsible County:

Phone(s): Home Work Other Phone & Type

Ethnicity (check all that apply and circle primary):

- American Indian or Alaskan Native Native Hawaiian/Other Pacific Islander
Asian Other/Unknown
Black/African American not of Hispanic Origin White

Annual Gross Income: \$

Program Initially Referred to

Admission Status (Registration): Not Enrolled Pending

Initial Service Provided:

# of units of service provided: Date:

- Acuity: Emergency (circumstances require that the assessment be completed within 3 hrs)
Urgent (assessment to be completed within 72 hrs)
Routine Appointments (assessment to be offered within 10 working days of initial contact, treatment to begin within 10 working days of the assessment)

Admission Date: Closing Date:

COMPLETE DIAGNOSIS INFORMATION ON BACK

**DIAGNOSIS**

- Always indicate the **Primary Diagnosis**.  
- Include all 5 Axes if possible. **Axes 1, 2, and 5 are required.**

**Axis**

**DSM-IV Code and Description**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Axis IV Type:**

- |  |   |
|--|---|
| <input type="checkbox"/> Economic Problem                    | <input type="checkbox"/> Occupational Problem                         |
| <input type="checkbox"/> Educational Problem                 | <input type="checkbox"/> Other Psychological or Environmental Problem |
| <input type="checkbox"/> Health Care Services Access Problem | <input type="checkbox"/> Primary Support Group Problem                |
| <input type="checkbox"/> Housing Problem                     | <input type="checkbox"/> Social Environment Problem                   |
| <input type="checkbox"/> Legal System Interaction Problem    |   |

**Axis IV Memo:**

\_\_\_\_\_

**Axis V**      **GAF:** \_\_\_\_\_      **GARF:** \_\_\_\_\_      **SOFAS:** \_\_\_\_\_      **CGAS:** \_\_\_\_\_

**Dual Diagnosis:**     Yes     No

**Has the client received services here before?**     Yes     No    **If yes, when?** \_\_\_\_\_

**Does the client have a Medical Card from the SRS?**     Yes     No

**Medical Card #:** \_\_\_\_\_

**ADAS Client?**     Yes     No      **Insurance?**     Yes     No

**Referring Agency:** \_\_\_\_\_

**Screener's/Admission Counselor's Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_