



OKLAHOMA DEPARTMENT OF HUMAN SERVICES



Confidential Intake Form

Intake date: _____ Worker: _____ Client level: _____

Section I. Identifying information.

Last name		First		Middle	
If a minor, name of guardian or custodial parent					
Finding street address		City		State	Zip
Street or P.O. Box mailing address		City		State	Zip
County of residence		Home phone		Work phone	
Social Security number			Age	Date of birth	
Sex	Race			Marital status	
U.S. citizen Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, what is your status?				
Education	High school <input type="checkbox"/>	Undergraduate <input type="checkbox"/>	Vocational/technical <input type="checkbox"/>		
	Post graduate <input type="checkbox"/>	Other <input type="checkbox"/>	_____		
Literate Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, explain				
Secondary language			Religious preference		

Other individuals in the home:

Name	Relationship

Who is the person you are closest to? _____

What is your relationship with your family? _____

Do you have any children? Yes No
 If yes, describe your relationship with them. If a minor child, what relationship do you have with your parents/guardian?

Are you ordered to pay child support? Yes No Monthly amount: _____

What is your mode of transportation?

- Own transportation
- Own transportation but may lose
- Own transportation, but cannot drive
- Public transportation
- Access to private transportation
- None

Section II. Employment and disability benefits

What is your employment status? _____

List your last or current occupation: _____

Does employer have a disability plan? Yes No

Have you applied for disability benefits? Yes No

If yes, what type? _____

Date of application: _____ Date of entitlement: _____

Financial:

Gross monthly income: _____ Source: _____

Monthly expenses:

Additional comments:

Section III. Medical

Insurance/Health care benefits

Name of insurer			
Street address	City	State	Zip
Phone number	Case or policy number	Effective date	
Name of insurer			
Street address	City	State	Zip
Phone number	Case or policy number	Effective date	

Are you enrolled in an experimental drug trial? Yes No
 If yes, please provide the name of the drug, the medical provider, and phone number:

Primary care physician or clinic			Phone number
Street address	City	State	Zip
Secondary care physician or clinic			Phone number
Street address	City	State	Zip

Date of first positive HIV test: _____

Have you been diagnosed with AIDS? Yes No

Estimated time of infection: _____

Latest CD4+ Count: Date: _____

Latest viral load: Date: _____

Other significant history:

Section IV. Legal

Have you been incarcerated? Yes No If yes, indicate dates and locations:

If your sentence is still pending, list file number: _____

Please give the following information.

Date to be discharged: _____

Current status in Department of Corrections: _____

Parole/probation officer's name: _____

Phone: _____ Extension: _____

Terms and conditions of parole or probation:

Do you pay any fines or restitution payments? Yes No

Amount due _____ How often? _____

If you need legal assistance for any of the following reasons, please check the assistance needed. You can check more than one.

- Estate planning _____
- Access to public assistance benefits _____
- Employment or insurance benefits _____
- Debtor or creditor issues _____
- Discrimination issues _____
- Other _____

- **Needs assessment check list**

- Prescriptions
- Housing
- Income
- Employment
- Physician services
- Hospital, inpatient services
- Hospital, outpatient clinic
- Dental care
- Eye care
- Household help
- Transportation
- Social Services help
- Individual counseling
- Group counseling
- Legal assistance
- Spiritual counseling
- Day programs
- Drug trial information
- Hospice care
- Foster care, children
- Day care, adults
- Day care, children
- Respite care
- Home health care
- Communication with medical provider
- Communication with AIDS service organization
- Interest in alternative therapies
- Support group
- AIDS/HIV education information
- Other: _____

Additional comments: