



INTAKE ASSESSMENT

This assessment is **Incomplete**

Legend:

Answers to Questions in Green are CONFIDENTIAL and will only be visible to your counselor. Indicates the start of a question with multiple sub-sections.

Personal Information:

Please fill out all questions to the best of your ability

| Question # | Question | Help | Answer Options |
|---------------------|--|------|---|
| 1. | Religion/Spirituality | ? | <input type="text"/> |
| 2. | Gender | ? | [select...] |
| 3. | Preferred Pronoun | ? | [select...] |
| 4. | Who are you attracted to? | ? | <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender |
| 5. | Hobbies | ? | <input type="text"/> |
| 6. Living Situation | | | |
| 6a. | Housing | ? | [select...] |
| 6b. | Household Description | ? | [select...] |
| 6c. | Zip Code you reside at most | ? | <input type="text"/> |
| 6d. | Do you live in a building owned or run by the Oakland Housing Authority? | ? | <input type="radio"/> Yes <input type="radio"/> No |
| 7. | Do you receive government assistance ? | ? | <input type="checkbox"/> EBT <input type="checkbox"/> Welfare <input type="checkbox"/> GA <input type="checkbox"/> Unemployment <input type="checkbox"/> SSI/SSDI <input type="checkbox"/> Section 8 <input type="checkbox"/> Victim of Crime <input type="checkbox"/> Other (describe) <input type="text"/> Other (Describe): <input type="text"/> |
| 8. Employment | | | |
| 8a. | Current Employment Status | ? | [select...] |
| 8b. | Employer (if employed) | ? | <input type="text"/> |
| 8c. | Current Resume ? | ? | <input type="radio"/> Yes <input type="radio"/> No |
| 9. | Do you have an IEP or 504 plan (for academic support) ? | ? | <input type="radio"/> Yes <input type="radio"/> No If Yes, Important Academic Information <input type="text"/> |
| 10. | Do you have a bank account ? | ? | <input type="radio"/> Yes <input type="radio"/> No |
| 11. | Do you have a driver's license? | ? | <input type="radio"/> Yes <input type="radio"/> No |

Physical Health:

Please fill out all questions to the best of your ability

| Question # | Question | Help | Answer Options |
|------------|---|------|--|
| 12. | Current physical health, ongoing health problems, and are you currently experiencing any pain? | ? | <input type="text"/> |
| 13. | Have you ever been hospitalized ? | ? | <input type="radio"/> Yes <input type="radio"/> No If Yes, Explain: <input type="text"/> |
| 14. | Please list any health condition which we need to know about for Job Training (allergies- especially bee allergies), asthma, surgeries, chronic illness ? | ? | <input type="text"/> |
| 15. | Have you or a family member ever been a victim of violence ? | ? | <input type="radio"/> Yes <input type="radio"/> No If Yes, How long ago: <input type="text"/> |
| 16. | Have you or a family member ever been involved in an incident involving violence ? | ? | <input type="radio"/> Yes <input type="radio"/> No If Yes, How long ago: <input type="text"/> |
| 17. | Are you taking any medication ? | ? | <input type="radio"/> Yes <input type="radio"/> No If Yes, please list: <input type="text"/> |
| 18. | Do you have health insurance ? | ? | <input type="radio"/> Yes <input type="radio"/> No If Yes, please name company and policy #: <input type="text"/> |

| | | |
|-------------------|---|--|
| 19. | Do you receive regular medical checkups ? | <input type="radio"/> Yes <input type="radio"/> No |
| 20. | Have you ever had a comprehensive STD screening ? | <input type="radio"/> Yes <input type="radio"/> No |
| 21. Glasses | | |
| 21a. | Do you wear glasses? | <input type="radio"/> Yes <input type="radio"/> No |
| 21b. | Do you need glasses? | <input type="radio"/> Yes <input type="radio"/> No |
| 22. Dental | | |
| 22a. | Do you receive regular dental check-ups? | <input type="radio"/> Yes <input type="radio"/> No |
| 22b. | Are you in need of any serious dental attention (including wisdom teeth)? | <input type="radio"/> Yes <input type="radio"/> No If Yes, please describe: <input type="text"/> |
| 23. | Do you have regular access to food ? | <input type="text" value="[select...]"/> |
| 24. | Are You Pregnant (females only) ? | <input type="radio"/> Yes <input type="radio"/> No |
| 25. Substance Use | | |
| 25a. | Substance Use (Check boxes, none checked assumed to be "None") | <input type="checkbox"/> Alcohol <input type="checkbox"/> Amphetamines (Meth, Speed/Uppers, crank etc.) <input type="checkbox"/> Cocaine/Crack <input type="checkbox"/> Opiates (Heroin, Opium, Methadone) <input type="checkbox"/> Hallucinogens (LSD, Mushrooms, Peyote, Ecstasy) <input type="checkbox"/> Sleeping Pills, Pain Killers, Valium or Similar <input type="checkbox"/> PCP (Phencyclidine) or designer drugs (GHB) <input type="checkbox"/> Inhalants (Paint, Gas, Glue, Aerosols) <input type="checkbox"/> Marijuana/Hashish/Pot <input type="checkbox"/> Tobacco / Nicotine <input type="checkbox"/> Caffeine / Energy Drinks <input type="checkbox"/> Prescribed & over the counter <input type="checkbox"/> Other substance |
| 25b. | To what level would you say your substance use is a barrier to your success ? | <input type="text" value="[select...]"/> |

Emotional and Mental Health Wellness:

Please fill out all questions to the best of your ability

| Question # | Question | Help | Answer Options |
|------------------------------------|---|---|--|
| 26. | Mental and Emotional Strengths (check all that apply) | <input type="checkbox"/> Artistic <input type="checkbox"/> Friend Support <input type="checkbox"/> Hopeful <input type="checkbox"/> Passionate <input type="checkbox"/> Social | <input type="checkbox"/> Clear Goals <input type="checkbox"/> Hard Working <input type="checkbox"/> Loyal <input type="checkbox"/> Positive Outlook <input type="checkbox"/> Spiritual strength <input type="checkbox"/> Committed <input type="checkbox"/> Healthy <input type="checkbox"/> Organized <input type="checkbox"/> Respectful <input type="checkbox"/> Survival Skills <input type="checkbox"/> Family Support <input type="checkbox"/> High Energy <input type="checkbox"/> Partner Support <input type="checkbox"/> Smart |
| 27. Mental and Emotional Struggles | | | |
| 27a. | I am struggling with or have struggled with in the past (check all that apply) | <input type="checkbox"/> ADD or ADHD <input type="checkbox"/> Check-in <input type="checkbox"/> Divorce <input type="checkbox"/> Fear <input type="checkbox"/> Health <input type="checkbox"/> Life Skills <input type="checkbox"/> Peer relations <input type="checkbox"/> Self-esteem <input type="checkbox"/> Thoughts of Hurting Self or Others | <input type="checkbox"/> Anger <input type="checkbox"/> Child Care <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Financial <input type="checkbox"/> Housing Problems <input type="checkbox"/> Loneliness <input type="checkbox"/> Punctuality <input type="checkbox"/> Sexuality <input type="checkbox"/> Work Site Issue <input type="checkbox"/> Anxiety <input type="checkbox"/> Death of Family or Friends <input type="checkbox"/> Eating Problems <input type="checkbox"/> Food/Hunger <input type="checkbox"/> Job Holding <input type="checkbox"/> Mental Health Concern <input type="checkbox"/> Relationship Concerns <input type="checkbox"/> Sleep Problems <input type="checkbox"/> Career Concerns <input type="checkbox"/> Depression <input type="checkbox"/> Family issues <input type="checkbox"/> Guilt or Shame <input type="checkbox"/> Legal <input type="checkbox"/> Other <input type="checkbox"/> School/Academic Problems <input type="checkbox"/> Staff Support |
| 27b. | To what level would you say emotional issues are a barrier to your success? | <input type="text" value="[select...]"/> | |
| 27c. | Do you feel that you have the skills and tools needed to manage your emotions ? | <input type="text" value="[select...]"/> | |
| 27d. | Current Therapist ? | <input type="text"/> | |
| 27e. | Other Notes: please list anything relevant to the topic of mental wellness ? | <input type="text"/> | |

Family/Social History:

Please fill out all questions to the best of your ability

| Question # | Question | Help | Answer Options |
|------------------|--|--|----------------|
| 28. Relationship | | | |
| 28a. | Relationship Status | <input type="text" value="[select...]"/> | |
| 28b. | How satisfied are you with your relationship status? | <input type="text" value="[select...]"/> | |
| 29. Children | | | |

| | | | |
|------|--|--|--|
| 29a. | Do you have Children? | | <input type="radio"/> Yes <input type="radio"/> No |
| 29b. | If Yes, How Many? | | <input type="text"/> |
| 29c. | If Yes (29a), Do you need childcare? | | <input type="radio"/> Yes <input type="radio"/> No |
| 30. | List important people growing up ? | | <input type="text"/> |
| 31. | List current family/friend or social supports ? | | <input type="text"/> |
| 32. | Were you adopted or raised by anyone other than your biological parents? | | <input type="radio"/> Yes <input type="radio"/> No If Yes, please describe: <input type="text"/> |
| 33. | Have you ever spent a day or more in a group home or foster home? | | <input checked="" type="radio"/> Yes <input type="radio"/> No |

33. Foster Care:

Please fill out all questions to the best of your ability

| Question # | Question | Help | Answer Options |
|------------|---|------|---|
| 33a. | How old were you when you first entered the foster system? | | <input type="text"/> |
| 33b. | How many placements did you have while in the foster system? | | <input type="text"/> |
| 33c. | What types of placement? | | <input type="text" value="[select...]"/> |
| 33d. | Length of time spent in foster care? | | <input type="text"/> |
| 33e. | Reason for exiting foster care? | | <input style="width: 150px;" type="text" value="[select...]"/> Other (Describe): <input type="text"/> |
| 33f. | Do you receive any of the following support from the foster system? | | <input style="width: 150px;" type="text" value="[select...]"/> Other (Describe): <input type="text"/> |

| | | | |
|------|---|--|--|
| 34a. | To what extent would you say that you have a support system of family or friends? | | <input style="width: 150px;" type="text" value="[select...]"/> |
| 34b. | Other Important Notes on family or supports? | | <input type="text"/> |

Legal:

Please fill out all questions to the best of your ability

| Question # | Question | Help | Answer Options |
|------------|---|------|---|
| 35. | Have you ever been arrested? | | <input type="radio"/> Yes <input type="radio"/> No |
| 36. | Have you ever been incarcerated? | | <input type="radio"/> Yes <input type="radio"/> No If yes, What was your release date? <input type="text"/> |
| 37. | Have you ever been convicted of an offense? | | <input checked="" type="radio"/> Yes <input type="radio"/> No |



37 Conviction / Probation / Parole:

Please fill out all questions to the best of your ability

| Question # | Question | Help | Answer Options |
|------------|--|------|--|
| 37a. | In what city? | | <input type="text"/> |
| 37b. | Do you reside in the same area? | | <input type="radio"/> Yes <input type="radio"/> No |
| 37c. | Juvenile case or Adult case(s)? (Check all that apply) | | <input type="checkbox"/> Juvenile <input type="checkbox"/> Adult |
| 37d. | Misdemeanor or Felony? (Check all that apply) | | <input type="checkbox"/> Misdemeanor <input type="checkbox"/> Felony |
| 37e. | Do you have any court dates pending? | | <input type="text"/> |
| 37f. | Are you currently on probation or parole? | | <input type="radio"/> Probation <input type="radio"/> Parole <input type="radio"/> Neither |
| 37g. | If Yes (#38f) Do you have a Parole Officer, or are you Unsupervised? | | <input type="radio"/> Parole Officer <input type="radio"/> Unsupervised |
| 37h. | If Yes (#38f), Until what date? | | <input type="text"/> |
| 37i. | If Yes (#38f), Name of Probation Officer: | | <input type="text"/> |
| 37j. | If Yes (#38f), Parole/Probation Officer Phone #: | | <input type="text"/> |
| 37k. | If Yes (#37f), PFN number ? | | <input type="text"/> |
| 37l. | Legal Support ? | | <input type="text"/> |

Future Goals:

Please fill out all questions to the best of your ability

| Question # | Question | Help | Answer Options |
|------------|--|---|----------------------|
| 38. | Goals and Aspirations ? |  | <input type="text"/> |
| 39. | Is there any other information you want the counselors to know ? |  | <input type="text"/> |

Save this Intake Assessment as INCOMPLETE

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