

FranksC Independent Living

7317 Yoe St.
Houston TX 77016
Intake / Social

Client Name: _____ Allergies: _____

Previous physical address: _____ Highest grade level completed: _____

Sex (circle): Male Female _____ Date of Birth: _____

Age: _____ GED/ Highschool Diploma: _____ College: _____

Diagnosis Eligibility Criteria:

Diagnosis: _____

Race (circle): White Black Hispanic other _____ Birth City and State: _____

Contact number: _____ Emergency Contact: ____-____-____

Medical Doctor Name: _____ Psychiatrist Name & number: _____

Are you part of the Waiver program: Act Team the Harris Center Texana Center gulf coast CPS VA

What program are you seeking: (circle) HCS -group home Assisted Living **Financial:** source of income:

SSI: _____ SSDI: _____ VA Pension: _____ other: _____

Parent's

Biological mother: _____ Biological father: _____

Were parents married at the time of your birth: (Circle) yes or no

Marital status: (Circle) Single Married Divorce widow

Previous hospitalizations: (List all within 6-months)

Last hospital admission date: _____ Discharge date: _____

Last hospital admission date: _____ Discharge date: _____

Hospital name address and phone number: _____

Hospital name address and phone number: _____

Other: _____

Reason for admission: _____

What attempts was done to self-harm? _____

What objects was used to self-harm? _____

FranksC Independent Living

7317 St.
Houston TX 77016

Do the individual have a history of seizure disorder? Yes or no If so what kind of seizure? _____

Please explain the seizure pattern: _____

Type of Drugs OD on: _____

Previous Drugs Use: _____

Does the client have a previous history of Abuse? (circle) yes or no

Physical: _____

Mental: _____

Sexual: _____

Other:

Current List of medication:

Name	Dose	PO/ IM	frequency

Activities you enjoy doing: _____

Information provided by: _____