Needs Assessment and Intake Form

Name:	
Address:	
Telephone number(s):	
Can messages be left at this phone number?	☐ Yes ☐ No
Emergency contact person:	
Emergency contact number:	

YES NO	Client Information
____ ____	**Are you single?** If no: 1-significant other, 2-married, 3-separated, 4-divorced, 5-widowed, 6-other
____ ____	**Do you rent your home or apartment?** If no: 1-own home, 2-live with relative(s), 3-live with friend(s), 4-not from this area, 5-homeless, 6: other
____ ____	**Do you speak another language besides English at home?** **If yes**, do you need a translator for appointments?
____ ____	**Are you in school now?** If no: 1-college graduate, 2-high school diploma, 3-GED, 4-dropped out of high school, 5-other
____ ____	**Are you interested in finding a job?** If no: 1-employed, 2-on disability, 3-enrolled in a training program, 4-other If disabled, what is the reason?
____ ____	**Do you need help with transportation to appointments?** What are you using now for transportation?
____ ____	**Do you have children?** If yes, how many? How many children live with you? Do any of your children have special needs?

____ ____	**Do you need help with childcare?**
____ ____	**Do you have any problems providing:** 1-housing, 2-food, 3-clothing, 4-utilities, 5-other:
____ ____	**Do you have any legal issues?**
YES NO	**General Health**
____ ____	**Do you need health insurance for yourself?** If no: Health insurance provider
____ ____	**Do you need a family doctor?** If no: Family doctor's name
____ ____	**Do you need a dentist?** If no: Dentists name
____ ____	**Have you ever had a mammogram?** **If yes,** when was your last mammogram?
____ ____	**Have you ever been diagnosed with breast cancer?** **If yes,** what was the type, stage, and overall outcome?
____ ____	**Have you ever been tested for an inherited genetic mutation that may increase your risk of breast cancer?** **If yes,** what were the results?
If you don't have a family doctor, where do you get your care? 1-ER, 2-Urgent Care, 3-Walk-in Clinic, 4-Other	
Previous illnesses:	
Previous surgeries and hospitalizations:	
Allergies:	
YES NO	**Current Medical Issues**
____ ____	**Are you currently being treated for any of the following conditions?** 1-infections, 2-asthma, 3-chronic medical conditions, 4-mental health conditions, 5-mental retardation, 6-developmental disabilities or delays, 7-other
____ ____	**Are you taking any medication?** 1-prescribed by your doctor, 2- over the counter, 3-herbal or alternatives, 4-other
YES NO	**Safety and Emotional Health**

____ ____	Do you use tobacco products?
____ ____	Does anyone smoke in your home?
____ ____	Do you drink alcohol?
____ ____	Do you use other substances?
____ ____	Are you stressed?
____ ____	Are you feeling depressed?
____ ____	Have you experienced emotional, verbal, or physical abuse?
____ ____	Do you have a working smoke detector?
____ ____	Are there any safety concerns in the home? Describe:
____ ____	Is there a gun in the home? If yes, is the gun locked? ☐ Yes ☐ No
____ ____	Are there any pets in the home?
List all other agencies you are working with now:	
NOTES:	

Please add the following Pathway(s): (These are samples of all the potential Pathways an individual can be assigned. Pathways required are listed in **PINK**. Additional Pathways are only required if you are offering and/or connecting individuals to that specific service.)

____ Adult Education

____ **Breast Health Screening**

____ **Breast Health Diagnostic**

____ **Breast Health Treatment**

____ Chemical Dependency

_____ Childcare Assistance

_____ Depression

_____ Employment

_____ Family Planning

_____ Family Violence

_____ Genetic Counseling/Testing

_____ **Health Insurance**

_____ Immunization Screening

_____ Immunization Referral

_____ Lead

_____ **Medical Home**

_____ Medical Referral

_____ Medication Assessment

_____ Medication Management

_____ Pregnancy

_____ Postpartum

_____ Smoking Cessation

_____ Social Service Referral

_____ Suitable Housing

_____ Transportation Assistance

_____ Other:

Next steps: