

**Northeast Veteran Training & Rehabilitation Center
Initial Intake Form**

Please fill in all requested information completely

Name: _____
Address: _____
SS#: _____ E-mail: _____
Phone where you can be reached: _____
Age: _____ DOB: _____ Gender: M ___ F ___ Race/Ethnicity: _____
Height: _____ Weight: _____
Referral Source: _____
Reason for Referral: _____

In Case of Emergency Contact:

Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

MILITARY

OIF/OEF Veteran _____ Security Clearance _____
Branch _____ Active Duty _____ National Guard _____ Reserve _____
Rank _____ Grade _____ Primary Military Occupation _____ Speciality _____
Certifications _____ Military Education, Training _____
Unit _____
Time in Service: Yrs _____ Months _____ Days _____
Time in Unit: Yrs _____ Months _____ Days _____
Time in theater: Yrs _____ Months _____ Days _____
Number of deployments: _____
Where _____ From _____ To _____
Where _____ From _____ To _____
Where _____ From _____ To _____
Where _____ From _____ To _____
Honors/medals/awards/decorations _____
Military Discharge (DD-214) _____ Discharge Type _____ Date: _____
(Please attach copy)
Legal military issues? _____
Satisfied with military experience? _____

Civilian legal actions (where/what/when/pending?) _____

VETERANS ADMINISTRATION (VA)

VA Claim Number _____

Disability: Yes ___ No ___ Rating % ___ In Process ___

If yes, how sustained: Combat ___ Non-combat ___ What _____

Where _____

Date(s) _____

Documented Yes ___ No ___

Need to speak to a Benefits Counselor? Yes ___ No ___

Name of Benefits Counselor and/or Case Manager _____

BACKGROUND

Born/Raised _____

HS Grad? _____ Suspensions/Expulsions _____ College _____

Associates of: _____ Bachelor of: _____ Master of: _____ Continuing Ed: _____

Single ___ Engaged ___ Married/Significant Other ___ How long _____

Divorced ___ How long _____ Number of times married _____

Spouse's Name: _____ Cell: _____

Children/Ages _____

Will your spouse live with you at the NVTRC? Yes ___ No ___

Will your children live with you at the NVTRC? Yes ___ No ___

HEALTH INSURANCE

Health Care Plan

Plan Number

1. _____

2. _____

HEALTH CARE PROVIDER(S) *Please list all current military and civilian providers, including practitioners of alternative therapies; e.g., Accupuncture, Accupressure, MassageTherapy, Yoga, Trainers, etc.*

	<u>Name</u>	<u>Address</u>	<u>Phone</u>
Primary Care Physician	_____	_____	_____
Psychiatrist	_____	_____	_____
Neuropsychologist	_____	_____	_____
Psychologist	_____	_____	_____
Social Worker	_____	_____	_____
Counselor	_____	_____	_____
Physical Therapist	_____	_____	_____

Occupational Therapist _____
Speech Therapist _____
Visiting Nurse _____
What other agencies are involved with your care? _____

MEDICAL RECORDS

Summary of medical history, last physical and last hospital admission. _____

Please attach copies of military and/or civilian records.

MEDICAL HISTORY (For additional space, please continue on reverse)

Current Diagnosis _____

Medications Please list (include over-the-counter & herbals)

Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____

Allergies Yes ___ No ___ Please list:

Allergen _____ Reaction _____
Allergen _____ Reaction _____
Allergen _____ Reaction _____

Vision Impairment Yes ___ No ___ Date _____

TB Test or Chest X-Ray Yes ___ No ___ Date _____

History of Injuries/Surgeries/Limitations (Please list & include dates)

SLEEP HABITS

Hours (currently) _____ Restful _____
Interrupted _____ Nightmares _____ Initial insomnia _____ Trouble awakening _____
Hours (previously) _____ Restful _____
Interrupted _____ Nightmares _____ Initial insomnia _____ Trouble awakening _____

PSYCHOLOGICAL / EMOTIONAL HEALTH

Have you seen a mental health provider? Yes ____ No ____

When _____ Provider _____

Where _____ Reason _____

Diagnosis _____

Are You Feeling Suicidal? Yes ____ No ____

Idea ____ Intent ____ Plan ____ Threats ____

Previous feelings _____

Previous attempts _____

Has a family member/close friend committed suicide? Yes ____ No ____

Are You Feeling Homicidal? Yes ____ No ____

If yes, toward whom _____

Previous feelings _____

Previous attempts _____

History of violent behavior? Yes ____ No ____

Do you have

Flashbacks Yes ____ No ____

Intrusive thoughts Yes ____ No ____

Paranoia Yes ____ No ____

Obsessive thoughts Yes ____ No ____

Excessive/irrational fears Yes ____ No ____

Hallucinations Yes ____ No ____

Auditory ____

Tactile (touch) ____

Olfactory (smell) ____

Visual ____

Gustatory (taste) ____

Problems with

Word retrieval ____

Memory ____

Confusion ____

Vision ____

GOALS

If accepted, what do you intend to gain from this program?

How do you plan to achieve this?

What are your expectations of this program?

How do you define success for yourself?

Why do you think you should be selected for this program?

Applicant Signature

Date

Staff Signature

Date