Visit our website at: www.osirisgroup.org
Tel: 617-442-2002
Fax: 617-442-4002
PO Box 190259
Boston, MA 02119

NHP INTAKE

Date: _____

Identified Client:	First Name	MI	Last Name				
Address	Number & Street		City	State	Zip		
Telephone	Day	Evening	Emergency				
Medical Coverage	Parent	Child	Expiration Date	ID Number			
Identified Client is:	Child	Age	Caretaker				
Gender	Male	Female	Transgender				
Race\Ethnicity	African-American	Hispanic\Latino	Asian	Native American			
Cont.	Caucasian	Haitian Creole	Cape Verdean	Other (Please Name)			
Biracial	Mother's Race\Ethnicity		Father's Race\Ethnicity				
Children in Family	*Mother's Family*	Girls	Boys	*Father's Family*	Girls	Boys	
Housing Difficulties	Present at referral	Yes	No	If Yes, Type of difficulty			
Guardian	Mother	Father	Other (describe)	Type of Employment			
Domestic Violence	Mother	Father	Other (describe)	Any domestic violence in the past 6 months? (describe)			
Cont.	Does perpetrator live in the home?		Other information on perpetrator				
Current Hospitalization	Yes	No	Reason	Hospital			
Past Hospitalization(s)	Yes	No	Reason(s)	No. Times	Hospital		

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Intake form continued

Ideations\Gestures	*Suicide*	Yes	No	*Homicide*	Yes	No	Other (describe)

DSM-IV Diagnosis	Describe		
Substance Abuse	Yes	No	History
Sex Abuse	Yes	No	History
Physical Abuse	Yes	No	History
Fire Setting	Yes	No	History
Running	Yes	No	History

Referred Child is in	Psychiatric Hospital	Residential Facility	Own Family Home	Foster Care	Group Home	Other (describe)
System Involvement	DSS	DMR	DYS	DMH	CHINS	Other (describe)
Intake Team						

Client Strengths\Interests:

Additional Comments: