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

NHP INTAKE FORM

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: