Intake Form

***[Intended to be collected verbally]***

**Participant Name:**

**Participant Study ID# (if participating in study, if not, leave blank):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FIT Location:**

[ ] Piedmont Health Services (Orange County) [ ] Lincoln Health Center (Durham County)

[ ] Charlotte Community Health Clinic (Mecklenburg County) [ ] WakeBrook (Wake County)

[ ] Advance Health (Wake County)

[ ] Triad Adult and Pediatric Medicine (Guilford County)

[ ] Other (please describe)

**Date of Birth:**

**Date of Release (or planned release if still incarcerated):**

**Date of Program Intake:**

Month Day Year

# Name of person administering Intake Form:

1. **Patient referred from or by:**

[ ] Prison (Specify Facility): [ ] Jail (Specify Facility): [ ] CHW (Specify): [ ] Probation/Parole (Specify department): [ ] Other; Specify

# What is the name of the last prison or jail where you were incarcerated prior to your release? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The next few questions are about your sexual orientation and gender identity. It is important for your health care providers to learn this information because every patient has unique health needs. Lesbian, gay, bisexual, and transgender (LGBT) people have some health needs that differ from others. Learning about sexual orientation and gender identity will help us to deliver better care to all of our patients. Your information is confidential and protected by law and will only be used to provide you with better care, not to discriminate against you. In addition, gathering this information from all patients allows the FIT program to see if there are differences in services across different populations, so we can improve the care we give to our patients. You don’t have to share this information. But feel free to bring it up with me or your provider in the future if you feel comfortable doing so.*

1. **What is your current gender identity?** (Check one): *[If needed, definition: Gender identity is a person’s inner sense of their gender. For example, a person may think of themselves as male, as female, as a combination of male and female, or as another gender.]*

[ ] Male

[ ] Female

[ ] Transgender Male/Trans Man/ Female-to-Male (FTM)

[ ] Transgender Female/Trans Woman/ Male-to-Female (MTF) [ ] Genderqueer, neither exclusively male nor female

[ ] Additional gender category, please specify: [ ] Choose not to disclose

1. **What sex were you assigned at birth?** (Check one): [ ] Male

[ ] Female

[ ] Choose not to disclose

1. **How would you describe your sexual orientation?** *[If needed, definition: Sexual orientation is how a person describes their emotional and sexual attraction to others.]*

[ ] Straight/heterosexual

[ ] Gay/lesbian/homosexual

[ ] Bisexual (attracted to both men and women) [ ] Other (please specify):

[ ] Choose not to disclose

# Do you consider yourself to be Hispanic or Latino/a?

[ ] Yes

[ ] No

[ ] Don’t know

1. **How would you define your race?** (Check all that apply): [ ] White

[ ] African American/Black

[ ] Asian (please specify):

[ ] Native Hawaiian or other Pacific Islander [ ] Native American or Alaskan Native

[ ] Other (please specify): [ ] Don’t know

# 8a. Do you speak a language other than English at home?

[ ] Yes

[ ] No (skip to Q.9)

# 8b. What language(s)?

[ ] Spanish

[ ] Other (please specify):

1. **Where do you live now?** (If response is unclear, prompt to select category) [ ] Homeless (living on the street, park, bus station, etc.)

[ ] In a shelter

[ ] Single room occupancy hotel [ ] Drug treatment facility

[ ] Other residential facility or institution (e.g. healthcare facility, halfway house) [ ] Staying with family/friends

[ ] Rent an apartment/house [ ] Own my home

[ ] Other (please specify):

# What is your current address?

|  |  |  |  |
| --- | --- | --- | --- |
| **Street** |  | | |
| **City** |  | | |
| **Zip** |  | **County** |  |

1. **What are other addresses where you may stay over the next 3 months, or are there addresses where you receive mail regardless of whether or not you stay there?** Please specify if it is mailing only (non-residential).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Mailing** | **Street** |  | | |
| **only?** |
| **City** |  | | |
| [ ] Yes |
| [ ] No |
| **Zip** |  | **County** |  |
| **Mailing** | **Street** |  | | |
| **City** |  | | |
| **only?** |
| [ ] Yes |
| **Zip** |  | **County** |  |
| [ ] No |
| **Mailing** | **Street** |  | | |
| **only?** |
| **City** |  | | |
| [ ] Yes |
| [ ] No |
| **Zip** |  | **County** |  |

1. **Are you concerned you may become homeless in the near future** (within 4 weeks?) [ ] Very concerned

[ ] A little bit [ ] Not sure

[ ] Not concerned at all

# What is the main reason you may become homeless?

[ ] Abuse/unsafe home [ ] Cannot pay bills

[ ] Cannot find a job

[ ] Other; specify

1. **Is there a place or places where you like to hang out?** Specifically, if we intend to meet with you in the community.

Place (s):

# What’s the best telephone number to reach you?

1. **Which are the best day(s) on which to contact you?** (Check all that apply)

[ ] Monday [ ] Tuesday

[ ] Wednesday [ ] Thursday

[ ] Friday

[ ] Saturday [ ] Sunday

1. **What time of day is best to contact you?** (Check all that apply) [ ] Morning [ ] Afternoon [ ] Evening

# Are there any other telephone numbers (that belong to someone with a stable address) through which we could reach you?

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship** | **Telephone Number** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **What is your inmate number? 20a. Do you have health insurance?**

[ ] Yes

[ ] No

[ ] Don’t know

# 20b. If yes, what kind of health insurance?

[ ] Medicaid [ ] Medicare

[ ] Employer provided insurance [ ] VA Insurance

[ ] Other (please specify):

1. **What is your Medicaid number?**
2. **What is your Medicare number?**

**23a. Are there any barriers you foresee to making clinic appointments?**

[ ] Yes [ ] No [ ] Not sure

**23b**. **If yes, what are they?** (Check all that apply) [ ] Transportation

[ ] Clinic hours

[ ] Communication (telephone, mail etc.) [ ] Childcare

[ ] Other; specify

|  |  |
| --- | --- |
| **24. Has a doctor ever told you that you have any of the following?** (check all that apply) | |
| a. Anemia or “low blood” |  |
| b. Angina or coronary heart disease |  |
| c. Heart attack or myocardial infarction |  |
| d. Congestive heart failure, also called weak heart or fluid on the lungs |  |
| e. Dementia or “Alzheimer’s” |  |
| f. Diabetes or high blood sugar |  |
| g. Liver disease or a bad liver or cirrhosis |  |
| h. Hepatitis C |  |
| i. Hepatitis B |  |
| j. HIV/AIDS |  |
| k. High cholesterol, lipids, or triglycerides |  |
| l. Hypertension or high blood pressure |  |
| m. Pancreatitis |  |
| n. Bad circulation in your legs or feet |  |
| o. Asthma |  |
| p. Chronic lung disease (emphysema, chronic bronchitis, or chronic obstructive lung disease (COPD)) |  |
| q. Kidney failure (or bad kidneys) |  |
| r. Stroke or “mini” stroke (Transient Ischemic Attack) |  |
| s. Anxiety/Depression |  |
| t. Bipolar disorder (Manic Depression) |  |
| u. Post-traumatic stress disorder (PTSD) |  |
| v. Schizo-affective/Schizophrenia (hearing voices or seeing things others don’t) |  |
| w. Substance use disorder/addiction |  |
| x. Alcohol use disorder/addiction |  |
| y. Any kind of cancer (please specify): |  |
| z. Chronic pain |  |
| aa. Other (please specify): |  |

5 FIT Program Intake Form

Version: 2.0 - October 29, 2020

# 25a. Have you ever received Therapy or Counseling?

[ ] Yes

[ ] No

# 25b. If yes, for What & When

1. **In the last 12 months, or since your release, where have you been seen for medical care? Please list the names of all facilities you can recall:**

Primary Care Offices:

Urgent Care Facilities:

Emergency Rooms:

Hospitals:

Other:

# Out of all these place, in the last 4 months, was there one place you usually went to when you needed routine or non-emergent care?

Place(s):

# Do you have a primary care provider?

Name:

# Have you gone a whole day without food in the last 4 months?

[ ] Yes

[ ] No

# Do you need assistance with any of the following issues during your reentry?

(Please check all that apply)

[ ] health insurance (Medicaid, Medicare, VA or other ?)

[ ] disability

[ ] food stamps

[ ] Temporary Family Assistance

[ ] family matters (including divorce & child custody, visitation, or support)

[ ] debt

[ ] housing

[ ] employment

[ ] domestic violence

# Do you currently need referral to the following?

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Mental Health Services |  |  |
| Substance Use Services |  |  |

1. **What are the current priorities that you would like to work on upon your release?** These could range from finding housing, getting a job, maintaining medication adherence, etc.)

# What barriers do you see to meeting these goals?

*[Describe the FIT Research Study to the client including purpose of study, 4-month follow-up survey phone calls and gift card incentive.]*

# Do you want to participate in the FIT Research Study?

[ ] Yes

[ ] No