BEACON OF HOPE

COMMUNITY SERVICES, INC.

INTAKE FORM

Individual Information: **Date:_____**

Name:_____ Date of Birth:_____

Address:_____ Phone:_____

_____ Email:_____

Male:_____ Female:_____ Race:_____ Religion:_____

Height:_____ Weight:_____ Hair:_____ Eyes:_____

Legal Status: Minor_____ Court Appointed Guardian_____

Name of Guardian:_____ Phone:_____

Address:_____

Social Security #:_____ Receiving Social Security Benefits: Y or N

Medical Diagnoses:_____

Medications/Dosage/Frequecny:_____

_____

Medication Allergies:_____

Special Diet Guidelines or Food Allergies:_____

_____

Primary Care Physician:_____ Phone:_____

Address:_____

Primary Insurance:_____ Number:_____

Other:_____ Number:_____

Emergency Contact Person:_____ Relationship:_____

Address:_____ **Phone**:_____

Does Beacon of Hope have permission to take individual to the hospital? _____

If not, what plan of action should Beacon of Hope take? _____

_____

Activities Enjoyed:_____

Activities Disliked:_____

Hobbies:_____

Fears:_____

Challenges (i.e. physical, behavioral, social, emotional, etc.):_____

_____

How are challenges avoided and/or managed:_____

_____

Contact information of person or company providing transportation to and from the program:

Name:_____ Phone:_____

Please mail form to: Beacon of Hope Community Services
P.O. Box 426
Leominster, MA 01453