V2 Staff Administered Intake

*** Indicates required fields.**

Housing & General Info

Agency ID

Intake Worker

Thank you for taking the time to talk to me today. The questions in this intake will help me get an idea of who you are and how we can best work together. First, a few general questions about you.

1. What do you think is your best quality?

2. What is something interesting about you?

3. What is your biggest strength?

4. Are you registered to vote? (If no, give instructions on how to register.)

- yes
- no

5. Have you served in the military?

- yes
- no

If YES, are you currently active duty?

- yes
- no

If YES, have you been deployed to a combat zone?

- yes
- no

6. Is a family member on active duty with the military?

- yes
- no

This next section is about your housing history. This information helps us figure out what services you might qualify for.

1. In the past 30 days, where have you been sleeping most of the time? (Ask as open ended question, then check appropriate box).

- On street
- Emergency shelter
- Transitional housing
- Residential psych facility
- Residential group home
- Residential drug treatment
- Nursing facility / hospice
- Hospital
- Correctional facility
- Permanent housing / rental
- Permanent housing
- Temp with relations / friend
- DV situation
- Other

2. How satisfied are you with the conditions of your living space?

- Very dissatisfied
- Dissatisfied
- Neither satisfied nor dissatisfied
- Satisfied
- Very satisfied
- Refused
- Don't know

3. Have you ever applied to a TIL / TLP program?

- yes
- no

If YES, what program?

4. Have you ever applied for Supportive Housing, Rapid Re-housing, or NYCHA/Section 8 Housing?

- yes
- no

If YES, what program?

5. Have you experienced any violence, abuse, discrimination, or disrespect at a housing program?

yes no

If YES, were any of these experiences because of your LGBTQ identity?

yes no

If YES, for each incident or experience, can you say more about that? When was this? Where did it take place?

6. What youth programs do you regularly attend, if any?

- The Door
- Streetworks
- Bronx Pride
- Fierce
- LGBT Center
- HMI
- Audre Lorde Project
- None
- Other

7. Have you ever been with these agencies?

Foster care Group home Both Neither

8. Are you currently A.W.O.L. from foster care or a group home?

Yes No N/A

9. Are you interested in info about returning to foster care (if under age 21)?

Yes No N/A

10. Have you ever or do you currently have an open ACS (child welfare) case?

yes no

11. Do you have a PINS (Person In Need of Supervision) warrant (if under age 18)?

Yes No N/A

12. Have you ever run away from home?

yes no

If YES, would you like to say more about that?

13. Have you ever been thrown out of your home or any living situation?

yes no

14. Were you ever thrown out of your home or any living situation for being LGBTQ?

yes no

15. Have you ever left home because of harassment due to your LGBTQ identity?

yes no

16. Did religion create a hostile environment for you in your home growing up?

yes no

17. Did your family's religious beliefs impact their view of you?

yes no

18. Did your family's religious beliefs cause you to feel a sense of rejection?

yes no

19. Were you treated differently from your siblings due to your LGBTQ identity?

Yes No N/A

20. Did you suffer physical abuse due to your LGBTQ identity?

yes no

21. Did you suffer verbal abuse due to your LGBTQ identity?

yes no

22. Have you ever been discriminated against due to your LGBTQ identity?

○ yes ○ no

23. Have you ever been victimized in any way for being LGBTQ?

○ yes ○ no

If YES, please explain.

Housing & General Info Notes

Update Housing & General Info

Physical Health & Nutrition

Now I'm going to ask you some questions about your health at the present time. One of the goals of the program is to make sure health services are available to you, and these questions will help us do that.

1. How would you rate your overall health right now?

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

What would you say is your biggest health problem at the present time?

2. Do you currently need emergency medical attention? (Do you need us to call 911?)

○ yes ○ no

3. Are you pregnant?

○ Yes ○ No ○ N/A

4. Are you currently engaged in hormone treatment?

○ yes ○ no

If YES, where do you get your hormones?

☐ Doctor ☐ Friend ☐ Street ☐ Other

If YES, do you ever share needles to inject your hormones?

○ yes ○ no

5. Have you ever been tested for TB (tuberculosis)?

○ yes ○ no

If YES, what was the date? (mo/year)

If YES, what was the result?

○ Negative for TB ○ Positive for TB

6. Where do you usually go to get medical care?

☐ Hospital ☐ Clinic ☐ Health van ☐ Urgent care / emergency room ☐ No source of care ☐ Other

(SKIP if answered no source of care) What is the doctor's name and location?

(SKIP if answered no source of care) When did you first go there for medical care?

(SKIP if answered no source of care) When was your most recent visit there?

7. When did you last receive a complete physical exam (mo/yr)?

8. In the past 6 months, has there always been someone you could go to for routine check-ups / advice about a health concern?

yes no

9. In the past 6 months, did you have any visits to the emergency room?

yes no

If YES, how many visits did you have?

If YES, what were the visits for?

10. In the past 6 months, were you in the hospital overnight or longer?

yes no

If YES, how many nights were you in the hospital?

If YES, what were you admitted for?

I'm going to read you several statements that people have made about their food situation. For these statements, please tell me about your past 30 days.

1. The first statement is: "The food that (I/we) bought just didn't last, and (I/we) didn't have money to get more." Was that often, sometimes, or never true for (you/your household)?

Often true Sometimes true Never true

2. I (we) couldn't afford to eat balanced meals.

Often true Sometimes true Never true

3. In the past 30 days, did you ever cut the size of your meals or skip meals because there wasn't enough money for food?

yes no

4. In the past 30 days, did you ever eat less than you felt you should because there wasn't enough money for food?

yes no

5. In the past 30 days, were you ever hungry but didn't eat because there wasn't enough money for food?

yes no

Physical Health & Nutrition Notes

Update Physical Health & Nutrition

Sexual Health

Next are questions about sexual experiences. We ask these questions as part of each person's health profile.

Have you ever had vaginal, anal, or oral sex?

yes no

If no, skip to question 4.

1. Who do you date most often? (Check all that apply)

Cismen Ciswomen Transmen Transwomen Other

2. In the past 6 months, who were your sexual partners? (Check all that apply)

- Cis women
- Cis men
- Transgender women
- Transgender men
- Gender nonconforming, non-binary, or genderqueer persons
- A person who was intoxicated or high
- A person who injects drugs
- A person who is HIV positive
- A person of unknown HIV status
- A person who exchanges sex for money, drugs, or a place to stay
- A person who is anonymous
- A person who is a hemophiliac

- ☐ A person who is MSM (cis Men who have Sex with cis Men)
- ☐ A person who is living with an STI
- ☐ A person who is living with Hep C
- ☐ Other

In the past 30 days, how many sexual contacts (vaginal, anal, or oral) did you have?

3. In the past 6 months, did you have sexual contacts without using condoms?

○ yes ○ no

In the past 30 days, how many sexual contacts did you have without using condoms?

4. What was the date of your last STI screening? (mo/year)

(SKIP if never tested) Where did you get tested?

(SKIP if never tested) In the past 6 months, did you test positive for any of the following STIs?

☐ Syphilis ☐ Gonorrhea ☐ Herpes ☐ Hepatitis ☐ Chlamydia ☐ None of the above ☐ Other

5. How often do you get screened for STIs (syphilis, gonorrhea, herpes, hepatitis, chlamydia)?

○ Every 4 months (quarterly) ○ Every month (monthly) ○ Every year (annually) ○ Never

6. What was the date of your last HIV test? (mo/year)

(SKIP if never tested) Where did you get tested?

(SKIP if never tested) What was the result?

○ HIV negative ○ HIV positive

7. How often do you get tested for HIV?

○ Every 4 months (quarterly) ○ Every month (monthly) ○ Every year (annually) ○ Never

Do you want to get tested for HIV today?

○ yes ○ no

8. Are you currently receiving treatment for any of the following?

☐ Syphilis ☐ Gonorrhea ☐ Herpes ☐ Hepatitis ☐ Chlamydia ☐ HIV ☐ None of the above ☐ Other

9. Are you currently in a sexual relationship with an HIV-positive person?

○ Yes ○ No ○ Don't know

10. PrEP is a daily pill taken to prevent HIV. Have you heard of PrEP?

○ yes ○ no

If NO, do you think you might benefit from being on PrEP?

○ Yes ○ No ○ Don't know

If YES, have you ever taken PrEP?

○ yes ○ no

If YES, have you taken PrEP in the past 6 months?

○ yes ○ no

If YES, where do you get your medication?

11. PEP is an emergency medication that can stop an HIV infection if started within 72 hours of exposure to HIV and continued for 28 days. Have you heard of PEP?

○ yes ○ no

If YES, have you ever taken PEP?

○ yes ○ no

If YES, have you taken PEP in the past 6 months?

○ yes ○ no

12. In the past 72 hours, have you had sex without a condom or shared a needle with someone who has HIV or whose HIV status you don't know? (If YES, refer immediately to Health Services Team.)

yes no

13. Have you ever exchanged sex for money, drugs, or a place to stay?

yes no

If YES, in the past 6 months?

yes no

Sexual Health Notes

Update Sexual Health

Mental Health

The next questions are about your mental or emotional health.

1. How would you describe your mood today?

2. Is your mood today different than your usual mood?

yes no

If YES, how is it different?

3. Have you ever been diagnosed with a mental or emotional health condition?

yes no

If YES, what diagnosis?

- Adjustment disorder
- Anorexia
- Anxiety
- Aspberger's
- Attention deficit disorder (ADD)
- Attention deficit hyperactivity disorder (ADHD)
- Autism
- Bipolar
- Bulimia
- Depression
- Generalized anxiety disorder
- Impulse control disorder
- Major depressive disorder (MDD)
- Manic disorder
- Obsessive compulsive disorder (OCD)
- Oppositional defiance disorder (ODD)
- Paranoia
- Personality disorder
- Post-traumatic stress disorder (PTSD)
- Schizophrenia

4. Have you ever been prescribed medications for mental or emotional health reasons?

yes no

If YES, which medications are you currently taking or have you taken before?

If YES, how long have / had you been taking this medication?

5. Have you ever received treatment from a mental health professional?

yes no

If YES, what is the name of your psychiatrist or therapist / clinic?

If YES, in the past 30 days, how many visits did you have for mental health services?

6. Have you ever been to a psychiatric emergency room or crisis center?

yes no

If YES, what were the visits for?

If YES, in the past 30 days, how many times were you in a psychiatric emergency room or crisis center?

7. Have you ever been hospitalized (admitted overnight) for mental health reasons?

yes no

If YES, what were the visits for?

If YES, in the past 30 days, how many nights were you in the hospital?

8. In the past 30 days, how many days have you:

a. Experienced serious depression

b. Experienced serious anxiety or tension

c. Experienced hallucinations

d. Experienced trouble understanding, concentrating, or remembering

e. Experienced trouble controlling violent behavior

9. Have you ever participated in any self-harming behavior? (For example - cutting, eating disorders, etc.)

yes no

If YES, can you tell me more about that? (For example - how old were you when you started?)

If YES, do you currently ___________ (fill in blank with identified behavior)?

yes no

10. Have you ever thought of committing suicide?

yes no

11. Have you ever attempted suicide?

yes no

If YES, can you tell me more about that? (For example - when? How did you go about the attempt?)

If YES, are you currently thinking of suicide?

yes no

12. Do you have concerns about being in close quarters with others?

yes no

13. Have you ever thought of hurting someone else?

○ yes ○ no

14. Have you ever thought of killing someone else?

○ yes ○ no

15. If YES, can you tell me more about that?

16. When was the last time you were in a physical fight? What happened?

17. People often have traumatic experiences – scary things that have either happen to them or that they have seen. I'm going to read a list of some possible things that sometimes happen to people. Please tell me if you've ever experiences any of these. You don't have to say anything more about them (unless you want to).

a. A really bad car or train accident

○ yes ○ no

b. A really bad accident at work or home

○ yes ○ no

c. A hurricane, flood, earthquake, tornado, or fire

○ yes ○ no

d. Hit or kicked hard enough to injure - as a child

○ yes ○ no

e. Hit or kicked hard enough to injure - as an adult

○ yes ○ no

f. Forced or made to have sexual contact - as a child

○ yes ○ no

g. Forced or made to have sexual contact - as an adult

○ yes ○ no

h. Attack with a gun, knife, or weapon

○ yes ○ no

i. During military service, seeing something horrible or being badly scarred

○ yes ○ no

j. Sudden death of close family or friend

○ yes ○ no

k. Seeing someone die suddenly or get badly hurt or killed

○ yes ○ no

l. Sudden move or loss of home and possessions

○ yes ○ no

m. Suddenly abandoned by spouse, partner, parent, or family

○ yes ○ no

n. Stalked

○ yes ○ no

o. Some other sudden event that made you feel very scared, helpless, or horrified, or any other terrible or frightening thing that may have happened to you

○ yes ○ no

If YES to final option, please specify.

19. Have you experienced physical assault or sexual abuse as a child / adult by (check if applicable):

☐ a family member ☐ current or former spouse or intimate partner ☐ current or former dating relationship ☐ acquaintance ☐ stranger

20. If you have a partner, how often does your partner:

a. physically hurt you?

☐ Never (01) ☐ Rarely (02) ☐ Sometimes (03) ☐ Fairly often (04) ☐ Declined to answer (05)

b. insult or talk down to you?

☐ Never (01) ☐ Rarely (02) ☐ Sometimes (03) ☐ Fairly often (04) ☐ Declined to answer (05)

c. threaten you with harm?

☐ Never (01) ☐ Rarely (02) ☐ Sometimes (03) ☐ Fairly often (04) ☐ Declined to answer (05)

d. scream or curse at you?

☐ Never (01) ☐ Rarely (02) ☐ Sometimes (03) ☐ Fairly often (04) ☐ Declined to answer (05)

Add the numbers from a to d to calculate score.

☐ **No partner.**

Are you interested in relationship counseling or support?

○ yes ○ no

21. Are you currently concerned for your safety?

○ yes ○ no

If YES, please explain.

22. The next questions are about how you've been feeling. I'm going to read you some statements, and you can tell me if you've felt this way not at all, several days, more than half the days, or nearly every day, in the past 2 weeks.

a. Little interest or pleasure in doing things

○ Not at all (0) ○ Several days (01) ○ More than half the days (02) ○ Nearly every day (03)

b. Feeling down, depressed, or hopeless

○ Not at all (0) ○ Several days (01) ○ More than half the days (02) ○ Nearly every day (03)

c. Trouble falling or staying asleep, or sleeping too much

○ Not at all (0) ○ Several days (01) ○ More than half the days (02) ○ Nearly every day (03)

d. Feeling tired or having little energy

○ Not at all (0) ○ Several days (01) ○ More than half the days (02) ○ Nearly every day (03)

e. Poor appetite or overeating

○ Not at all (0) ○ Several days (01) ○ More than half the days (02) ○ Nearly every day (03)

f. Feeling bad about yourself, or that you are a failure, or that you have let yourself or your family down

○ Not at all (0) ○ Several days (01) ○ More than half the days (02) ○ Nearly every day (03)

g. Trouble concentrating on everyday tasks

○ Not at all (0) ○ Several days (01) ○ More than half the days (02) ○ Nearly every day (03)

h. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving arounc a lot more than usual

○ Not at all (0) ○ Several days (01) ○ More than half the days (02) ○ Nearly every day (03)

i. Thoughts that you would be better off dead, or of hurting yourself

○ Not at all (0) ○ Several days (01) ○ More than half the days (02) ○ Nearly every day (03)

***Add the numbers from a to i to calculate depression score. If total is between 20 and 27, note in intake summary.**

j. Feeling nervous, anxious, or on edge

○ Not at all (0) ○ Several days (01) ○ More than half the days (02) ○ Nearly every day (03)

k. Not being able to stop or control worrying

○ Not at all (0) ○ Several days (01) ○ More than half the days (02) ○ Nearly every day (03)

l. Worrying too much about different things

○ Not at all (0) ○ Several days (01) ○ More than half the days (02) ○ Nearly every day (03)

m. Trouble relaxing

○ Not at all (0) ○ Several days (01) ○ More than half the days (02) ○ Nearly every day (03)

n. Being so restless that it's hard to sit still

Not at all (0) Several days (01) More than half the days (02) Nearly every day (03)

o. Becoming easily annoyed or irritable

Not at all (0) Several days (01) More than half the days (02) Nearly every day (03)

p. Feeling afraid as if something awful might happen

Not at all (0) Several days (01) More than half the days (02) Nearly every day (03)

***Add the numbers from j to p to calculate anxiety score.**

23. Are you interested in weekly supportive therapy for any of the things we just talked about?

Yes No Possibly Already have a therapist

Mental Health Notes

Update Mental Health

Substance Use & Legal

Next are some questions about the use of alcohol and other substances. We ask these questions as part of everyone's profile. All your answers are completely confidential.

Have you ever drank alcohol or used drugs, including tobacco? (If yes to only tobacco, select "No" or "Never" to the following questions and skip to question 11.)

yes no

1. Have you ever used any of the following?

	Ever used?	Used in past 30 days?	How often in past 30 days?
Cocaine/crack	yes no	yes no	
Marijuana, hash, pot, weed	yes no	yes no	
K2/spice	yes no	yes no	
Heroin or speedball	yes no	yes no	
Other opiates (morphine, percocet, codeine, oxycontin, non-prescription methadone, etc)	yes no	yes no	
Hallucinogens/psychedelics, angel dust/PCP, ecstasy/MDMA, LSD/acid/mushrooms	yes no	yes no	
Speed/amphetamines/methamphetamine/adderrall/crystal meth/uppers	yes no	yes no	
Valium/tranquilizers/downers	yes no	yes no	
Glue, poppers, other inhalants	yes no	yes no	
Any alcohol use	yes no	yes no	
Alcohol to intoxication (alcohol use to get very drunk)	yes no	yes no	

Any other drug? yes no

Please specify.

Used in past 30 days? yes no

How often in past 30 days?

In the past 12 months, have you injected drugs?

yes no

In the past 30 days, have you injected drugs?

yes no

If YES, how often did you use a syringe / needle that someone else used?

Daily Weekly Monthly A few times

2. In the past year, have you drank or used drugs more than you meant to?

- Yes
- No
- Declined to answer

3. In the past year, have you felt you wanted or needed to cut down on your drinking or drug use?

- Yes
- No
- Declined to answer

4. During the past 30 days, how stressful have things been for you because of your use of alcohol or other drugs?

Never Rarely Sometimes Fairly often

5. During the past 30 days, has your use of alcohol or other drugs caused you to reduce or give up important activities?

Never Rarely Sometimes Fairly often

6. During the past 30 days, has your use of alcohol or other drugs caused you to have emotional problems?

Never Rarely Sometimes Fairly often

7. How old were you when you first began using alcohol?

8. How old were you when you first begin using drugs?

9. Have you ever received any type of alcohol or drug treatment?

- Yes
- No
- Did not answer

10. Are you seeking drug or alcohol treatment now?

- Yes
- No
- Did not answer

11. Do any members of your immediate family use drugs?

Yes No Don't know

12. Do you smoke cigarettes?

- Yes
- No
- Did not answer

If YES, how old were you when you started smoking cigarettes?

If YES, would you like help quitting smoking?

yes no

Legal Background

1. Did you ever have contact with the justice system before the age of 18?

- Yes
- No
- Did not answer

2. Have you ever been arrested?

- Yes
- No
- Did not answer

If YES, what for?

If YES, in the past 30 days, how many times have you been arrested?

If YES, in the past 30 days, how many times have you been arrested for drug-related offenses?

3. Have you ever been to jail/prison?

- Yes
- No
- Did not answer

If YES, what for?

If YES, in the past 30 days, how many nights have you spent in jail / prison?

4. In the past 30 days, how many times have you committed a crime?

5. Are you currently awaiting charges, trial or sentencing?

- Yes
- No
- Did not answer

6. Are you currently on parole or probation?

- Yes
- No
- Did not answer

7. Have your parents/guardians ever been in jail/prison?

- Yes
- No
- Did not answer

8. Do you presently need any assistance with legal matters? If YES, what for?

Substance Use & Legal History Notes

Update Substance Use & Legal

Social Support & Family

1. About how many close friends do you have who you trust and you can count on to support you if you needed advice or help with a problem?

2. About how many close relatives do you have who you trust and you can count on to support you if you needed advice or help with a problem?

3. About how many other people do you know through an organization, program, or agency who you might ask for help or advice?

4. Do you use social networking websites for support?

yes no

5. If YES, which sites do you use?

☐ Facebook ☐ Instagram ☐ Snapchat ☐ Other

6. Do you have someone you consider your best friend?

○ yes ○ no

7. Do you have someone you would like us to contact, in case of an emergency?

○ yes ○ no

What is their name and contact info?

What is that person's relationship to you?

8. How satisfied are you with your personal relationships?

☐ Very dissatisfied ☐ Dissatisfied ☐ Neither satisfied or dissatisfied ☐ Satisfied ☐ Very satisfied

The next questions are about your family history.

1. Do you have contact with the person you consider to be your mother?

○ yes ○ no

If YES, is this person your:

☐ Birth mother
☐ Adoptive mother
☐ Step-mother
☐ Foster mother
☐ Grandmother
☐ Aunt
☐ Sister
☐ House mother
☐ Other

2. How would you describe your relationship with this person?

3. Do you have contact with the person you consider to be your father?

○ yes ○ no

If YES, is this person your:

☐ Birth father
☐ Adoptive father
☐ Step-father
☐ Grandfather
☐ Uncle
☐ Brother
☐ Other

4. How would you describe your relationship with this person?

5. Are you interested in building a relationship with your family?

☐ Yes ☐ No ☐ Did not answer

6. Would family reunification be an option for you?

☐ Yes ☐ No ☐ Did not answer

7. Do you have brothers or sisters?

○ yes ○ no

If YES, what are their names, ages, locations?

8. Do you have children?

○ yes ○ no

If YES, what are their names, ages, locations?

If YES, are any of your children living with someone else due to a child protection court order?

☐ Yes ☐ No ☐ N/A

If YES, how many of your children are living with someone else due to a child protection court order?

If YES, for how many of your children have you lost parental righs?

Social Support and Family History Notes

Update Social Support & Family

Self-Esteem & Goals

This section is about how you feel about yourself at the present time. These kinds of questions help us learn more about you and help us make better programs for you. Please tell me how much you agree or disagree with each of the following statements. Your answer can be strongly agree, agree, disagree, or strongly disagree.

I take a positive attitude toward myself.

○ (3) Strongly Agree ○ (2) Agree ○ (1) Disagree ○ (0) Strongly Disagree

On the whole, I am satisfied with myself.

○ (3) Strongly Agree ○ (2) Agree ○ (1) Disagree ○ (0) Strongly Disagree

I feel that I'm a person of worth, at least on an equal plane with others.

○ (3) Strongly Agree ○ (2) Agree ○ (1) Disagree ○ (0) Strongly Disagree

I feel that I have a number of good qualities.

○ (3) Strongly Agree ○ (2) Agree ○ (1) Disagree ○ (0) Strongly Disagree

I am able to do things as well as most other people.

○ (3) Strongly Agree ○ (2) Agree ○ (1) Disagree ○ (0) Strongly Disagree

All in all, I am inclined to feel that I am a failure.

○ (0) Strongly Agree ○ (1) Agree ○ (2) Disagree ○ (3) Strongly Disagree

I feel I do not have much to be proud of.

○ (0) Strongly Agree ○ (1) Agree ○ (2) Disagree ○ (3) Strongly Disagree

I wish I could have more respect for myself.

○ (0) Strongly Agree ○ (1) Agree ○ (2) Disagree ○ (3) Strongly Disagree

I certainly feel useless at times.

○ (0) Strongly Agree ○ (1) Agree ○ (2) Disagree ○ (3) Strongly Disagree

At times I think I am no good at all.

○ (0) Strongly Agree ○ (1) Agree ○ (2) Disagree ○ (3) Strongly Disagree

***Add the numbers above to calculate score.**

You're almost done. This is the last section, and it's about your goals.

What goals do you want to achieve while at AFC?

How do you hope to personally grow while at AFC?

That's the last question we have. Is there anything I didn't ask that you'd like me to know?

Thank you for taking the time to complete this intake and for sharing your experiences with me.

Update Self-Esteem & Goals

SAVE