



Welcome

To better serve you, please read and complete this form

Phone Number: (617) 684-6209

Fax Number: (617) 249- 0408

Email: familiasoutpatientintake@casaesperanza.org

1. Today's Date: _____		
2. Full Name: _____	3. Do you go by any other names/nicknames: <input type="checkbox"/> Yes: _____ <input type="checkbox"/> No	
4. Date of Birth: _____		
5. Address:		
Number & Street/Apt # _____	City: _____	State/Zip: _____
6. Phone: _____	7. Email: _____	
8. Mental Health Diagnosis: _____		
9. Language Capacity: _____		
10. Substance of choice current or past: <input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine <input type="checkbox"/> Crack <input type="checkbox"/> Heroin <input type="checkbox"/> Marijuana Other: _____	Date of First Substance Used: _____	Date of Last Use: _____
11. Referral Information		
Referral Reason: _____		
Referral Source: <input type="checkbox"/> Self Referral <input type="checkbox"/> Provider <input type="checkbox"/> Other: _____		
<i>If provider, please indicate:</i>		
Name: _____ Organization: _____ Phone: _____ Email: _____		
12. Health Insurance Information (Check all that apply):		
<input type="checkbox"/> No Health Insurance <input type="checkbox"/> Medicaid/Mass Health (<i>Indicate Health Insurance Plan</i>): _____		
<input type="checkbox"/> Application Pending <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare		
<input type="checkbox"/> OT- State Subsidy (<i>eg. Commonwealth Care, Health Safety Net</i>) <input type="checkbox"/> Other: _____		
Insurance Co.: _____		Policy Name: _____
Policy Number: _____	Group #: _____	Policy Start Date: _____