

Crisis Contact Form

Name: _____

Address: _____

_____, _____, _____
City State Zip Code

Address Type
 Client Billing
 Client Home
 Client Previous
 Client Work

Home Phone (____) _____ - _____

Facility: _____

Intake Staff: _____

Date of Service: _____

Crisis Contact: Complete All Fields

1. Gender: Male Female
2. Date of birth:
MM DD YY
3. Social Security #:

4. Initial Contact
 By Appointment
 Other
 Phone
 Walk-in

5. County of Residence _____
 NA, Out of State

6. Pregnant: Yes No Unknown

7. HIV Positive: Yes No Unknown

8. Past IV Drug Use: Yes No

9. Presenting Problem (client's own words):

10. Program Enrollment: _____

11. Race:
 Caucasian
 Black/African American
 American Indian
 Asian
 Hawaiian or Pacific Islander
 Alaskan Native
 Unknown
 Not Collected

12. Ethnicity
 Not Spanish/Hispanic/Latino/
Mexican
 Puerto Rican
 Mexican
 Cuban
 Other Hispanic or Latino
 Not Collected

13. Years of education

14. Veteran Status
 None
 Served in Armed Forces
 In Reserves
 Active Duty
 Combat History
 National Guard
 Retired from Military/National Guard
 Active Duty, No Combat
 Active Duty, Combat
 Unknown
 Military Dependent

15. Days Waiting: _____