Patient Intake Form / Assessment

MISSION

Face Forward International's mission is to provide emotional support and reconstructive surgery for women, children and men who have been victims of Domestic Violence, Human Trafficking or any Cruel Acts of Crime.

Please help us by filling out the form below as completely and as honestly as possible. Your responses will be strictly confidential. Please send 2 before and 2 after photos along with the form.

Name (Last, First, M.I.):	**Sex:**	**DOB:**
Marital Status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**		
Social Security Number:	**Phone Number:**	
Address:	**Email Address:**	
Are you currently receiving services through a Veteran Services Organization(s) ? If so, which one(s)?	**Military Branch/Rank:**	
Years of Active Duty:	**War or Military Action where injury received:**	
Do you have health insurance?	**If yes, what type of insurance:**	
Have you ever been convicted of a crime?	**If yes, explain:** *Please note that this does not exclude you from possible services.	
Are you currently employed?	**If so, what type of work?**	
Are you currently in school/university?		

*All Face Forward patients are subject to a drug test and background check.

What can Face Forward do for you? Tell us your story.

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?			☐ Yes	☐ No
	Have you considered stopping?			☐ Yes	☐ No
	Have you ever experienced blackouts?			☐ Yes	☐ No
	Are you prone to "binge" drinking?			☐ Yes	☐ No
	Do you drive after drinking?			☐ Yes	☐ No
Tobacco	Do you use tobacco?			☐ Yes	☐ No
	☐ Cigarettes-pks./day	☐ Chew#/day	☐ Pipe#/day	☐ Cigars#/day	
	☐ # of years	☐ Or year quit			
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?			☐ Yes	☐ No
Personal Safety	Do you live alone?			☐ Yes	☐ No

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No
Have you ever been hospitalized or diagnosed with a mental illness?	☐ Yes	☐ No