THE WISE ORG
The Women's Inspirational and Self-Empowerment Org
1296 Cronson Blvd Suite 3681
Crofton Maryland 21114

INTAKE ASSESSMENT

Privacy Policy: We will not share, sell, or rent your information with any third party outside of our organization. We understand the importance of privacy and are committed to maintaining the confidentiality of your personally identifiable information and/or medical history.
Disclaimer: Applicants not qualifying for our program are automatically referred to one of our many resource-partners to receive pre-support services.

Instructions: Please provide the following information for our records.

Full Name:_____
Full Address:_____
_____
Date of Birth: _____ **Age:** _____ **U.S. Citizen: ( )YES ( ) NO**
Phone 1: _____ **Phone 2:** _____
Email: _____

In case of emergency, who may we contact on your behalf?

Full Name: _____ **Relationship:**_____
Phone: _____ **Address:**_____

Full Name: _____ **Relationship:**_____
Phone: _____ **Address:**_____

CURRENT STATUS AND HISTORY

Are you married? ( )YES ( ) NO	**If yes, spouse name?**
Do you have children? ( )YES ( ) NO	**If yes, how many? Age(s)?**
Living Arrangements? (own, rent, living with others, shelter, homeless) →	
Employment? ( )YES ( ) NO	**If yes, ( ) Full Time ( ) Part Time** **Employer Name: _____** **Length of Employment: _____**
Highest Level of Education? (GED/High School, Some College, College Degree, Graduate School, Other) →	
Do you consume alcohol beverages? ( )YES ( ) NO	**If yes, how often?** **( ) 1 to 3 times per week** **( ) 4 to 10 times per week** **( ) 10+ times per week**
Do you smoke? ( ) YES ( ) NO	**If yes, have you ever tried to quit?** **( ) YES ( ) NO**
Have you in the past, or currently: Used, Abused, Experimented with illegal drugs? ( ) YES ( ) NO	**If yes, briefly explain:**

Do you suffer from anxiety? ( ) YES ( ) NO	**If yes, how often?** **( ) 1 to 3 times per week** **( ) 4 to 10 times per week** **( ) 10+ times per week** **( ) 3 to 5 times per month**
Do you suffer from depression or experience depressive moods? ( ) YES ( ) NO	**If yes, how often?** **( ) 1 to 5 times per week** **( ) 5 to 10 times per week** **( ) 10+ times per week** **( ) 3 to 5 times per month**

Are you having suicidal thoughts? ( ) YES ( ) NO **Have you ever attempted suicide? ( ) YES ( ) NO**	**If yes, how often?** **( ) 1 to 5 times per week** **( ) 5 to 10 times per week** **( ) 10+ times per week** **( ) 3 to 5 times per month** **If yes, describe briefly and indicate dates:**
Have you ever had a psychiatric hospitalization? ( ) YES ( ) NO	**If yes, describe briefly and indicate dates:**
Are you currently seeing a counselor, psychiatrist, therapist, psychotherapist, psychologist? ( ) YES ( ) NO	**If yes, circle all that apply:** Counselor, Psychiatrist, Therapist, Psychotherapist, Psychologist

Currently taking medication prescribed by a licensed physician? ( ) YES ( ) NO **Have you ever been professionally diagnosed with any chronic illness, disability, medical conditions and/or impairments? ( ) YES ( ) NO**	**If yes, please list medication name:** **If yes, please list date and name of diagnosis:**
Have you ever received or given abuse? ( ) YES ( ) NO	**If yes, circle all that apply from each column:** **RECEIVED GIVEN** **Physical / Physical** **Emotional / Emotional** **Sexual / Sexual** **Neglect / Neglect** **Other / Other**

Do you suffer from PTSD? ( ) YES ( ) NO **(Post Traumatic Stress Syndrome is flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about an event you witnessed and/or experienced.)**	**If yes, describe briefly your PTSD:** **If yes, have you sought treatment:** **( ) YES ( ) NO**

Have you ever been arrested? ( ) YES ( ) NO	**If yes, how many times?**
Have you ever been convicted of a crime? ( ) YES ( ) NO	**If yes, describe briefly and indicate dates:**
Are you currently on probation or parole?( ) YES ( ) NO	**If yes, describe briefly and indicate dates:**

Circle Your TOP 5 Immediate Needs

Safety	**Food**	**Obtaining Vital Records**
Housing	**New Job**	**Budgeting/Financial Planning**
Transportation	**Clothing**	**Investment Planning**
Mental Health Concerns	**Career Planning**	**Credit Repair**
Physical Health Concerns	**College (New/Returning)**	**Banking (Opening Checking/Savings Acct**
Vocational Training	**Continuing Education**	**Health Insurance**

HOW CAN WE HELP YOU

1. What brought you to The W.I.S.E. Org?

_____
_____
_____
_____
_____

2. What do you hope to gain if you are selected for The W.I.S.E. Org program(s)?

_____
_____
_____
_____
_____

3. Is there anything that would be a hindrance in completing your program/goals if you are selected?

_____
_____
_____
_____
_____

PLEASE SIGN AND DATE BELOW

APPLICANT SIGNATURE: _____

DATE: _____