CLIENT INTAKE FORM

Date _____

How did you hear about our office?_____

What is your current legal matter?_____

_____

_____

Adverse Parties: _____

Biographical Information

Name:_____

Address: _____
(Is this your RESIDENCE or MAILING ADDRESS?)

Home Phone number: _____

Cell Phone number _____

Email Address: _____

Date of Birth:_____

Social Security:_____

Education (What is the highest grade you completed?):_____

Are you a veteran (circle one)? YES NO

Household Information

Marital Status: (circle one)
Single
Married
Divorced
Widowed
Living As Married

Living Circumstances (circle one):

Alone
With Family
Rooming House
Public Housing
Homeless Shelter
Number of members in household: _____

Are you receiving any of the following housing assistance (circle one)?

Emergency Assistance (TRA) Section 8 Housing Assistance

Other: _____

Financial Information

Are you working? (circle one) YES NO

If yes, where are you working? _____

How long have you been working there? _____

What is your salary? _____

If you are not working, what is your source of income? _____

SSI (Monthly Amount): _____

SSD (Monthly Amount): _____

General Assistance/SNAP (Monthly Amount): _____

Alimony (Monthly Amount): _____

Pension (Monthly Amount):_____

Child Support (Monthly Amount): _____

Are you currently enrolled in any of the following? (circle one)

Educational Training Vocational Training College Student

Medical History

Have you ever been hospitalized due to a mental condition? (circle one) YES NO

What is the total amount of times you have been hospitalized? _____

Within the last 30 days have you been discharged from a hospital? (circle one) YES NO

If yes, please indicate which hospital _____

_____

Within the last 30 days have you been discharged from a short-term care facility or involuntary psychiatric unit? (circle one) YES NO

If yes, please indicate the name of the facility _____

What is your mental health diagnosis? _____

Are you currently engaged in mental health treatment? (circle one) YES NO

If yes, where and how often do you go _____

_____

If not, how long has it been since you were last treated? _____

Are you taking medication? (circle one) YES NO

If yes, please list your medication(s) _____

_____

Who is your Psychiatrist/Psychologist? _____

What is their contact information? _____

Who is your therapist? _____

What is their contact information? _____

Who is your case worker? _____

What is their contact information? _____

CITIZENSHIP OR LAWFUL RESIDENT STATUS

County of Bergen Mental Health Law Project receives state and county funding which requires us to inquire of all of its clients whether you are a citizen or lawful resident of the United States.

Please check:

_____ I am a citizen of the United States of America or

_____ I am a lawful resident of the United States.

I hereby certify that the information contained in the Client Intake Form is accurate and correct.

Signature: _____ **Date**: _____

CERTIFICATION IN LIEU OF AFFIDAVIT OF INDIGENCY

I, _____, do hereby certify that:

1. **I am indigent and without funds to pay either legal fees or court costs.**
2. **I hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.**

Signature: _____ **Date:** _____

REPRESENTATION AGREEMENT

I hereby employ the Bergen County Mental Health Law Project to represent me in connection with the following matter:

_____

_____

_____

and to receive, copy and inspect any and all records in connection with said matter.

I understand that I must fully cooperate with the Bergen County Mental Health Law Project to assist me in their representation and that I must immediately notify them of any change of address, telephone number, income or employment. If I do not cooperate with Bergen County Mental Health Law Project, I understand that Bergen County Mental Health Law Project may close my file if there is no pending court or agency proceeding, or ask the court/agency for permission to withdraw as my attorney.

I also understand that Bergen County Mental Health Law Project is under no obligation to file an appeal on my behalf should there be a decision which I consider unfavorable.

_____ _____

Client's Name Director

Dated: