



We are now accepting applications for our new facility located in the Historic West End of Atlanta, GA. Pregnant women in need are encouraged to apply.

Intake Form Date: _____
Referred By: _____
Name: _____
Phone Number: _____
Email: _____ Religious Affiliation: _____
Where are you currently staying? City?: _____
Birthdate: _____ Age: _____
Place of Birth: _____ Citizenship: _____
Race: _____
Social Security Number: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Engaged ___ Separated
Do you own a car? ___ Yes ___ No In your name? ___ Yes ___ No Is it paid off? ___ Yes ___ No
Do you have a valid Driver's License? ___ Yes ___ No
Do you have car insurance? ___ Yes ___ No
Highschool Diploma or GED? _____ Date: _____

Section 1

- 1) Are you currently pregnant? Yes No
- 2) How many weeks pregnant are you? _____
- 3) What is your expected due date? _____
- 4) What was the date of your last prenatal doctor visit? _____
- 5) Doctor's Name: _____
- 6) Doctor's Phone Number: _____
- 7) How are you feeling about your pregnancy?

- 8) Are you having a boy or a girl? _____

Section 2

1) Are you receiving WIC at this time? Yes No 2) Are you on any type of government assistance? Yes No If you answered yes, please list which ones.

3) Do you have insurance? () Medicaid () Medicare () Private () Medical Assistance () VA () None () Other : _____

Section 3

1) Do you have any of the following?

Mental Health Issues Yes No Explain: _____

Drug Issues Yes No Explain: _____

Alcohol Issues Yes No Explain: _____

Asthma Yes No Explain: _____

Diabetes Yes No Explain: _____

Allergies Yes No Explain: _____

Developmental Disability Yes No Explain: _____

Physical Disability Yes No Explain: _____

HIV/AIDS Yes No Explain: _____

Victim of Domestic Violence Yes No Explain: _____

Chronically Mentally Ill Yes No Explain: _____

Special Needs Yes No Explain: _____

Unspecified Disability Yes No Explain: _____

Communicable Illness Yes No Explain: _____

Tuberculosis Yes No Explain: _____

Learning Disability Yes No Explain: _____

Lupus Yes No Explain: _____

Attention Deficit Disorder Yes No Explain: _____

1) Are you on medication? Yes No If yes, please list and explain: _____

2) Do you have any other health problems? Yes No If yes, please explain: _____

3) Are there any emotional problems in your family? Yes No If yes, please explain: _____

4) History of drug or alcohol abuse in your family? Yes No If yes, please explain: _____

5) Have you used: Alcohol Yes No First Time _____ Last Time _____ Marijuana Yes No First Time _____ Last Time _____ Cocaine/Crack Yes No First Time _____

Last Time _____ Heroin Yes No First Time _____ Last Time _____ Meth Yes No
First Time _____ Last Time _____ Prescription Drugs Yes No First Time _____
Last Time _____ Pain Killers Yes No First Time _____ Last Time _____

6) Do you smoke? Yes No

Section 4

Your Mother's Name: _____

Whereabouts: _____

Your Father's Name: _____

Whereabouts: _____

What is your relationship like with your family?

Do you know who the father is? Yes No

Baby's Father's Name: _____

Whereabouts: _____

How did you meet? _____

How long have you known him? _____

What do you like about him? _____

Can you describe his personality? _____

Does he know you are pregnant? Yes No

How does he feel about it? _____

Does he have a history of drug use? Yes No

Have you used drugs together? Yes No

Does he own a weapon? Yes No

Has he threatened you? Yes No

Has he threatened others? Yes No

What is your relationship like with your baby's father?

Section 5

Have you been pregnant before? Yes No If yes, how many times? _____

Do you have any children? Yes No Please list all of your children's names:

Child's First Name: _____ Last Name: _____

Age: _____ Date of Birth: _____ Gender: _____

Child's Father's Name: _____

Who has legal custody? _____

Child's First Name: _____ Last Name: _____

Age: _____ Date of Birth: _____

Gender: _____

Child's Father's Name: _____

Who has legal custody? _____

Child's First Name: _____ Last Name: _____

Age: _____ Date of Birth: _____

Gender: _____

Child's Father's Name: _____

Who has legal custody? _____

Child's First Name: _____ Last Name: _____

Age: _____ Date of Birth: _____ Gender: _____

Child's Father's Name: _____

Who has legal custody? _____

Section 6

Have you experienced physical, emotional, or verbal abuse? (Please Explain)

Have you experienced sexual abuse? (Please Explain)

Is your family aware of this? _____

Have you ever sought counseling? _____

Are you in danger? _____ By Whom? _____

Section 7

Are you currently under court authority, for any reason? Yes No If yes, explain:

Are you on probation or parole? Yes No If yes, explain:

Do you have any pending charges? Yes No If yes, explain:

Do you have any prior convictions? Yes No If yes, explain:

Do you acknowledge that we will run a background check before you are accepted into Auntie Angie's House? Yes No

Signature: _____

Date: _____

Section 8

How will this program help you?

What are your views on God?

How do you deal with stress?

How do you typically deal with conflict?

How do you feel about structure and chores?

How do you feel about authority?

Emergency Contact: Name: _____

Address: _____

Phone Number: _____

Relationship: _____

References: Name: _____

Address: _____

Phone Number: _____

Relationship: _____

Please complete, print and email this application along with a copy of your Government issued ID to: info@theakf.org