



GENERAL INTAKE FORM Information on Identified Client

Date: _____

Identified Client:				
	First Name	MI	Last Name	
Address				
	Number & Street		City	State Zip
Telephone				
	Day	Evening	Emergency	
Medical Coverage				
	Parent	Child	Expiration Date	ID Number
Identified Client is:				
	Child	Age	Caretaker	
Gender				
	Male	Female	Transgender	
Race/Ethnicity				
	African-American	Hispanic/Latino	Asian	Native American
<i>Cont.</i>				
	Caucasian	Haitian Creole	Cape Verdean	Other (Please Name)
Biracial				
	Mother's Race/Ethnicity		Father's Race/Ethnicity	
Children in Family	<i>Mother's Family</i>		<i>Father's Family</i>	
	Girls	Boys	Girls	Boys
Housing Difficulties	Present at referral			
			Yes	No
	If Yes, Type of difficulty			
Guardian				
	Mother	Father	Other (describe)	Type of Employment
Domestic Violence				
	Mother	Father	Other (describe)	Any domestic violence in the past 6 months? (describe)
<i>Cont.</i>				
	Does perpetrator live in the home?		Other information on perpetrator	
Current Hospitalization				
	Yes	No	Reason	Hospital
Past Hospitalization(s)				
	Yes	No	Reason(s)	No. Times Hospital



Intake form continued

Ideations\Gestures	<i>Suicide</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Homicide</i>	<input type="checkbox"/>	<input type="checkbox"/>	Other (describe)
		Yes	No		Yes	No	

DSM-IV Diagnosis	Describe
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Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	History
	Yes	No	

Sex Abuse	<input type="checkbox"/>	<input type="checkbox"/>	History
	Yes	No	

Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	History
	Yes	No	

Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	History
	Yes	No	

Running	<input type="checkbox"/>	<input type="checkbox"/>	History
	Yes	No	

Referred Child is in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Psychiatric Hospital	Residential Facility	Own Family Home	Foster Care	Group Home	Other (describe)

System Involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	DSS	DMR	DYS	DMH	CHINS	Other (describe)

Intake Team	
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Client Strengths\Interests:

Additional Comments: