A CENTER FOR HOPE AND CHANGE

Client Intake Form

Client Name:

Parent/Guardian Name (if applicable):

Date of Birth:

Age:

Social Security Number:

Medicaid/Insurance Number:

Home Phone:

Mobile/Alternate Phone:

Address:

How Long at This Address?

School (if applicable):

Grade:

Ever Retained:

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When?

Referred By:

Describe any problems in the home:

Does the child harm animals when angry? Yes / No

Does the child play with fire? Yes / No

Describe any problems at school:

Behavioral interventions used at school:

In-School Suspensions (ISS):

Out-of-School Suspensions:

Reasons for Suspension:

Have parents met with school counselor/principal? Yes / No

If yes, who attended: Parent(s) / Guardian(s) / Both

Any legal issues we should be aware of?

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Current Medications:

Prescribed By:

For how long?

Health Insurance Provider:

Primary Care Physician (PCP):

PCP Address:

PCP Phone Number:

Date of Assessment Scheduled:

Date of Intake:

Staff Completing Intake: