☐ Website
☐ Walk In
☐ Telephone
☐ RQMC
☐ Fax

☐ English
☐ Spanish
☐ Primary

INITIAL INTAKE/REFERRAL

1st Call_____	Program_____
2nd Call_____	Funding check_____
In EXYM_____	Assess Date_____
To Access_____	Clinician_____

Intial Contact Date _____

Referred By

Is Parent / Guardian aware of referal? ☐ Yes ☐ No ☐ N/A

Name & Phone Number	Relationship	Date of Contact

Client Info

Last Name	First Name	MI	Ethnicity	Age

DOB	Gender	School	Grade	SSN

Parent/Guardian 1

Last Name	First Name	MI	Relationship

Street Address	City	Zip

Home Phone	Cell Phone	Work Phone

Employer Name	Employer Address

Parent/Guardian 2

Last Name	First Name	MI	Relationship

Street Address	City	Zip

Home Phone	Cell Phone	Work Phone

Employer Name	Employer Address

Financial

Medical _____ Other insurance _____ Primary Dr. _____

What are your child's strengths? What is working well?

What are your concerns?

What do you think needs to happen?

Safety Concerns? ☐ Yes ☐ No
Safety Plan? ☐ Yes ☐ No
Describe Safety Plan

On a scale of 0-10, with 0 being that you feel your child is safe from harming himself or being hurt by others and that you can keep him safe, and 10 being that your child is in imminent danger and you do not feel that you can keep him from being harmed, where would you say that number belongs?

Family Data

Marital Status: ☐ M ☐ LT ☐ D ☐ S ☐ W ☐ SEP

Court order regarding child's legal custody? ☐ Yes ☐ No

If yes, does parent have a copy of court order? ☐ Yes ☐ No

What is parent's understanding of court order? _____

Caregiver affidavit required? ☐ Yes ☐ No

Psychiatric History / Previous Therapy

Presenting Problems

☐ URGENT ☐ Self Harm ☐ Dev Disability ☐ Weapons
☐ Abuse ☐ Substance Abuse ☐ Homicidal ☐ Parental Mental Illness
abuse type:_____ ☐ Domestic Violence ☐ Community Violence
☐ Other_____

DSS Involvment

Has the DSS Child Abuse Hotline ever been contacted about suspected abuse? ☐ Yes ☐ No ☐ N/A

Who Contacted DSS? _____

Has a DSS Social Worker talked to you or your child? ☐ Yes ☐ No

Open Case ☐ Yes ☐ No

Name of Social Worker _____ Location _____

Address _____ Phone _____ Fax _____

Resources Needed

☐ Housing/Shelter ☐ Food ☐ Parenting ☐ Financial Assistance
☐ Clothing ☐ Education ☐ Child Care ☐ Other_____

Household

Last Name	First Name	Age	Relationship to child	Gender

Disposition

☐ URGENT

Funding Source

☐ Medi-Cal ☐ CHAT ☐ MHSA ☐ SELPA

Location

☐ Ukiah ☐ Willits ☐ Covelo ☐ Laytonville

PCIT

☐ Yes ☐ No

Assessing Clinican _____ Treating Clinican _____

Refer to another agency _____

_____ _____

VSC/Intake Coordinator signature Date