

Western Family Center

Client Crisis Intake Form

Please complete the information below to the best of your knowledge and ability. The information provided will help us at the Western Family Center provide you with the utmost, acute care possible. All information provided is confidential and privileged information for authorized personnel of the Western Family Center for the purpose to determine services and eligibility. Should you have any questions or need any assistance in completing this form, please see our representative at the front desk.

Do you require any special accommodations (i.e. interpreter)? If yes, please explain: _____

Have you received services from the Western Family Center before? Yes No

If yes, when and what type of service? _____

Client name: _____ DOB: _____ Sex: Male Female

Address: _____ Mailing, if different: _____

Contact number: _____ Best time and day to be contacted: _____

Emergency contact information (name & number): _____

Employer: _____ Employer contact info: _____

Occupation: _____ Annual income: _____ Marital status: _____

Highest level of completed education: _____

Current medical physician: _____ Physician contact info: _____

Do you currently have medical insurance coverage? Yes No If yes, please indicate the name & type of coverage: _____

Date of last hospitalization: _____ Reason: _____

Please list all current health conditions (i.e. pregnancy, depression, mental health, etc.): _____

Are you currently taking drugs in which have been prescribed to you? Yes No

If yes, please list: _____

Do you currently consume drugs that you do not have a prescription for? Yes No

If yes, please indicate the substance and how often: _____

Do you consume alcoholic beverages? Yes No If yes, how often: _____

Do you receive any of the following services? Please check all that apply:

Public Assistance

_____ Food Stamps

_____ Medical Coupons

_____ TANF

_____ Child Care Assistance

_____ WIC

Disability Benefits

Housing Assistance

Child Support

Other: _____

Household Composition (Please list all who reside with you):

<u>Name</u>	<u>Age</u>	<u>Relationship to Client</u>

Please briefly describe your reason for visiting the Western Family Center today: _____

Listed below are some services offered at the Western Family Center. Please check all those that you would be interested in receiving more information:

- | | | | |
|-------------------------------------|------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Referrals | <input type="checkbox"/> Life Skills | <input type="checkbox"/> Financial |
| __ individual | __ medical | __ anger management | __ Budgeting |
| __ couples/marriage | __ shelter | __ domestic violence counseling | |
| __ family | __ food | __ parenting classes | |

Please list any other services you might be interested in that are not listed above: _____

I acknowledge that I have completed the foregoing information to the best of my knowledge and ability. I understand the above information will be used for the sole purpose of the Western Family Center to provide me care and all information provided written and verbal is confidential information between myself and authorized personnel at the Western Family Center.

Client Signature

Print Name

Date

Parent/ Guardian/ Interpreter Signature

Print Name

Date

For official use only:

Date: _____ Time: _____ am/pm Intake Counselor name: _____

Intake Summary: _____
