# WesTCOAST CHILDREN’S CliNIC INTAKE INTERVIEW

Please Fax this Form to 510-373-1632 Attn: Intake

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| **REFERRAL INFORMATION** | | | | |
| Name of Person Referring:  Agency:  Phone:  Relationship to Client: | Client Name:  Date of Birth:  Race:  Social Security #:  Medi-Cal #: | | | Sex Assigned at Birth  Gender Identity:  Gender Expression:  Sexual Orientation:  Client Pronouns: |
| Address (if homeless, indicate city):  Phone: | Living Situation:  ☐ Family ☐ Group Home  ☐ Foster ☐ AWOL  ☐ Other:  Languages Spoken:  Interpreter Needed? ☐ Yes ☐ No | | | Who Does the Client Live With?  History of Running Away? ☐ Yes ☐ No  What City/State was the Client Born In? |
| Who Has Legal Authorization to Consent for Treatment? | Is the Client a Current or Former Foster Youth? ☐ Yes ☐ No | | | Is the Client Involved in the Juvenile Justice System? ☐ Yes ☐ No |
| Emergency Contact Name:  Emergency Contact Phone: | Child Welfare Worker:  Phone:  Fax:  Email: | | | Attorney:  Phone:  Probation Officer:  Phone: |
| Primary Caregiver:  Relationship to Client:  Languages Spoken:  Interpreter Needed? ☐ Yes ☐ No | Biological Mother:  Address:  Phone:  Okay to Contact? ☐ Yes ☐ No  Languages Spoken: | | | Biological Father:  Address:  Phone:  Okay to Contact? ☐ Yes ☐ No  Languages Spoken: |
| **PRESENTING CONCERNS**  Why Are Services Requested Now? | | | | |
| **STRENGTHS**  What are the Client’s Strengths? | | | | | |
| Concerns About Suicidality or Homicidality? Does the Client Have Ideation, Intent, Plan? ☐ Yes ☐ No If Yes, Why? | | | Concerns About Sexual Exploitation? ☐ Yes ☐ No If Yes, Why? | | |
| Safety Concerns? ☐ Yes ☐ No If Yes, Why? | | | Concerns About Trauma? ☐ Yes ☐ No If Yes, Why? | | |
| **ACADEMIC FUNCTIONING**  School: Grade:  Special Education Services? | | | | | |
| **MEDICAL HISTORY** | | | | | |
| Primary Care Physician:  Phone:  Current Medications: | | | ☐ Major Illnesses:  Allergies? ☐ Yes ☐ No (please list): | | |
| **MOST RECENT THERAPEUTIC SERVICES**  Agency:  Therapist:  Phone:  Type of Services:  Length of Services:  Client Response: | | | **SERVICES REQUESTED**  ☐ Outpatient Therapy: ☐ **Individual** OR ☐ **Family**    ☐ C-Change: (For Minors Who Are at Risk of or Currently Involved in Sexual Exploitation)  ☐ Psychological Testing    ☐ EMPOWR: (For youth ages 16-24 needing team-based help in building support system)  Special Service Requests: | | |
| **HISTORY WITH WESTCOAST CHILDREN’S CLINIC**  Does the Client or Family Have a History with WestCoast Children's Clinic? ☐ Yes ☐ No | | | | | |
| **SERVICE LOCATION PREFERENCES AND AVAILABLITY** | | | | | |
| Service Location Preference:  ☐ Home  ☐ School  ☐ Office  ☐ Community  ☐ Flexible  ☐ Other:  Is Client able to Travel to the Office? ☐ Yes ☐ No  Preferred Days and Times for Services: | | |  |  | | --- | --- | |  | If services are provided through Telehealth:  Does the client have the technology needed to attend a telehealth appointment? |   ☐ Yes ☐ No | | | |
| **PSYCHOLOGICAL TESTING REFFERALS ONLY** | | | | | |
| Who is Requesting Testing?   |  | | --- | |  | | Has the client been tested previously? Did they receive a diagnosis? Who completed the testing? Can WestCoast receive a copy?  What questions should the assessment address? What are the goals of testing? How will results of testing affect the client's treatment plan? | |  | | |  |  |  |  | | | | | | |