# 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 BirthGender 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 ☐ NoWhat 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 ☐ NoLanguages Spoken: | Biological Father:Address:Phone: Okay to Contact? ☐ Yes ☐ NoLanguages 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:  |

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|   | 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?

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| 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? |   |
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