Midwest Family & Community Resources
Intake Form

PHONE: 708.745.3040
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INTAKE ASSESSMENT FORM

Date of Referral: **Counseling:** ☐ **Assessment**: ☐

Client Information:

Name (Last, First, MI):		**DCFS ID #:**	
Address:		**Home Phone:**	
City, State, Zip Code:		**Work Phone:**	
Placement Type:		**OK to leave message:**	
Date of Birth		**Male/Female:**	
Age:		**Primary Language**	
Religion:		**Legal Status**	

Race:	African American	☐	Hispanic	☐	Asian	☐	Native American	☐	White/Non-Hispanic	☐	

Multiple Clients in the Family: #2

Name (Last, First, MI):		**DCFS ID #:**	
Address:		**Home Phone:**	
City, State, Zip Code:		**Work Phone:**	
Placement Type:		**OK to leave message:**	
Date of Birth		**Male/Female:**	
Age:		**Primary Language**	
Religion:		**Legal Status**	

Race:	African American	☐	Hispanic	☐	Asian	☐	Native American	☐	White/Non-Hispanic	☐	

Multiple Clients in the Family: #3

Name (Last, First, MI):		**DCFS ID #:**	
Address:		**Home Phone:**	
City, State, Zip Code:		**Work Phone:**	
Placement Type:		**OK to leave message:**	
Date of Birth		**Male/Female:**	
Age:		**Primary Language**	
Religion:		**Legal Status**	

Race:	African American	☐	Hispanic	☐	Asian	☐	Native American	☐	White/Non-Hispanic	☐	

Referral Source:

DCFS	☐	**Private Agency**	☐	**Grant**	☐	**Insurance**	☐	**Self-Referral**	☐	**Other:**	☐

Name (Last, First, MI):		**Phone:**	
Address:	**Same as above**	**Relationship:**	
City, State, Zip Code:		**Agency:**	
Supervisor:	**Phone:**	**Fax:**	

Party Responsible for Payment:

Private Agency:		**Private Pay:**	
Other:			
DCFS:		**Region:**	

Reminder: Caseworker is expected to meet with client and therapist initially, in order to clarify goals and create collaborative approach to case. Caseworker will be utilized throughout assessment process.

Parent/Guardian or Foster Parent Information:

Name (Last, First):		**Home Phone:**	
Address:		**Work Phone:**	
City, State, Zip Code:		**Pager/Cell:**	

Reason for Referral/Presenting Problem:

Barriers to Treatment:

Services Requested (Please check all that apply):

				Format Requested:			
General Counseling	☐	**Relationship Prob.**	☐	**Individual**	☐	**Family**	☐
Behavior Management	☐	**Parenting Capacity**	☐	**Couple**	☐	**Group**	☐
Emotional Problems	☐	**Parenting Coaching**	☐	**Assessment Only**	☐		
Abuse/Neglect	☐	**Adoption**	☐				
				In Home	☐	**In Office**	☐
Other (Please Explain):				Other:			

Please Elaborate on any Checked Items:

Time Preferred**:**

Mornings	☐	Days	☐	After school	☐	Evenings	☐	Saturdays:	☐
8-12am	☐	12-3pm	☐	3-5pm	☐	5-9pm	☐	Other:	☐

Reminder: Transportation needs to be set up prior to initial meeting if client cannot self-transport or caretaker cannot provide consistent transportation. Also, consider safety concerns with aggressive clients regarding self-transportation.

PRESCREENING: Please answer yes or no if client(s) has a history of any of the following:

	Yes	No		**Yes**	No
Alcohol and/or Drugs	☐	☐	**Psychotropic Medication**	☐	☐
Homicidal Behavior	☐	☐	**Self-Mutilating**	☐	☐
Mental Illness	☐	☐	**Sexual Aggression**	☐	☐
Psychiatric Hospitalization	☐	☐	**Suicidal Ideation**	☐	☐
Psychotic Behavior	☐	☐	**Violence/Weapons**	☐	☐
Family Violence **Other:**	**Medications**				

Please Elaborate on any Checked Items:	

Prior Involvement with Midwest Family & Community Resources?

Yes	☐	**No**	☐	**Other**	☐
Please Explain					

It is imperative that all court orders are included with the referral packet. Your signature below indicates that any and all active court orders were included with the referral packet or there were no active court orders at the present time.

Referring Agency Information:

Agency's Name:		
I understand that referring this client to Midwest Family and Community Resources for services obligates my agency to pay for such services.		
Referring Worker's Name and Title:		
Please Sign and Date:		
	Signature	**Date**
Supervisor's Name and Title:		
Please Sign and Date:		
	Signature	**Date**

For Office Use Only

State of Referral:	**Waiting to be Assigned**	☐	**Assigned**	☐	**On Hold**	☐	**Transferred**	☐
	Returned to Agency	☐	**Terminated**	☐	**Closed**	☐	**Other**	☐

Completed by:	

CHECK OFF LIST FOR REFERRALS

Mandatory

Referral Form	**Yes**	☐	No	☐	**Other**	☐
Payment Authorization	**Yes**	☐	No	☐	**Other**	☐
Unusual Incident Report(s)/ Court Orders	**Yes**	☐	No	☐	**Other**	☐
Social History	**Yes**	☐	No	☐	**Other**	☐
Expected						
Service Plan	**Yes**	☐	No	☐	**Other**	☐
Current of Recent Assessment	**Yes**	☐	No	☐	**Other**	☐
Previous Therapy Reports(s)	**Yes**	☐	No	☐	**Other**	☐
Current or Recent Psychological	**Yes**	☐	No	☐	**Other**	☐
Any other Supporting Documents	**Yes**	☐	No	☐	**Other**	☐

Please List the Documents Below: