MY PEOPLE
CLINICAL SERVICES
Support • Empower • Rebuild

(860) 656-0450 Phone | 860-656-0491 Fax | info@mypeople-ct.com Email | mypeople-ct.com Web

Universal Intake Form

Date of Referral:_____
Client Name:_____ Date of Birth:_____
Ethnicity:_____ Marital Status:_____ Education:_____
Is the client a child (Under 18): ☐ Yes ☐ No

Parent/Guardian Name:_____

Address:_____ City:_____ State:_____

Phone Number:_____ Cell Phone:_____

Additional Children in the home:

Reason(s) for Referral

Gillett Street, Hartford, CT 06105
(860) 656-0450 Phone | 860-656-0491 Fax | info@mypeople-ct.com Email | mypeople-ct.com Web

(860) 656-0450 Phone | 860-656-0491 Fax | info@mypeople-ct.com Email | mypeople-ct.com Web

Clinical Diagnoses:

Axis I-

Axis II-

Axis III-

Medical/Health Concerns:

Safety Concerns:

Past History of Treatment (Include hospitalizations, residential care, past legal involvement, dates of treatment, foster care etc.)**:**

Expected Outcomes/Goals:

(1.)

(2.)

(3.)

(860) 656-0450 Phone | 860-656-0491 Fax | info@mypeople-ct.com Email | mypeople-ct.com Web

List Current Providers:

Are you currently involved with DCF?: ☐ Yes ☐ No

DCF Social Worker Name:_____ **Office Number:**_____
Supervisor Name:_____ **Office Number:**_____

DCF Level of Involvement (circle one):

☐ Protective Services ☐ Commitment ☐ Vol. Services ☐ OTC
☐ Investigations

Referral Type (circle one):

☐ Intensive Home Based Services ☐ Individual Therapy ☐ Family Therapy
☐ Parent Mentoring ☐ Father to Father Program Supervised Visits

Name of foster parent:_____

Additional Information: