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:**_____

**Reason(s) for Referral:**

**Child(ren) names/Date of Birth:**_____
_____
_____
_____

**Address:**_____**Ethnicity**_____**Marital Status:**_____

**Education:**_____
**Phone Number:**(Home)_____(CellPhone)_____

**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:_____

Gillett Street, Hartford, CT 06105
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Address:_____Phone Number:_____

**Clinical Diagnoses:**

Axis I-

Axis II-

Axis III-

**Current/ Past Services:**_____
_____
_____
_____

**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.)

**List Current Providers:**

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## Additional Information: