Child Abuse Prevention Services, Inc.

INTAKE FORM FOR COUNSELING / THERAPY

DATE: ____________________

Last Name First Name

Address City State Zip

DOB Sex

Current Phone Alternate Phone

School and Grade

Parents' or Guardians' Name(s)____

Who has legal custody____

Address if different:____

Phone if different: ____________________________

Referred By: _________________________ Phone: ___________________

If DSS case, has abuse been substantiated__________________________
Or is it a family "in need of services"____________________________

IF DSS CASE, PLEASE ADVISE THEM TO FORWARD WRITTEN CONFIRMATION OF LEGAL CUSTODY AND SUBSTANTIATION OR FAMILY "IN NEED OF SERVICES".

Date of abuse:___________ Alleged perpetrator:________________________________

Details of abuse:____

Medicaid: Yes ( ) No ( ) If yes #:________________________________

Insurance Co.: _____________________ Policy #____________________

Information taken by:_________ Assigned to:_________________________

Revised 5-06