WARD ADVOCACY, LLC

CHILD/PARENT INTAKE FORM

Please check appropriate boxes. If asked a question, fill in information on designated space.
All words that are bold are required information.

Source of Referral: ☐ Self ☐ Friend _____ ☐ Other _____

☐ Community Agency_____ ☐ Church_____

Date of Initial Intake _____

Revised Date: _____

Reviewed Date(s): _____

Client Identification

Last name _____

First name _____ MI _____

Date of birth _____ Age _____

WAID# _____

Address information (provide current address)

Street address: _____

City _____ State ____ Zip _____

Phone _____ email _____

Is this your mailing address? ☐ Yes ☐ No

If no, please provide other address:

Street address: _____

City _____ State ____ Zip _____

Confidentiality Issues

Can we call ?	☐ Yes	☐ No
Identify as WA client?	☐ Yes	☐ No
Send mail?	☐ Yes	☐ No
Can we email?	☐ Yes	☐ No

Special instructions: _____

Personal Information (check one only)

Sex: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐ White ☐ Black/African American

☐ Asian ☐ Native American

☐ Native Hawaiian/Pacific Islander

☐ More than one race

☐ W/ parents or guardian only

☐ Lives in foster care

☐ Lives in chronic care facility

Needs Identified: ☐ None ☐_____

Plan: _____

Total persons in household _____

Language/Education Information

Client's spoken language _____

Client's written language _____

Caregiver spoken language _____

Caregiver written language _____

OFFICE USE ONLY: ALL INFORMATION ON PAGE VERIFIED & UPDATED
1ST Review Date:_____ 2nd Review Date:_____ WA STAFF:____

Contact Information / Social Support

Please check ☐ if contact has to be done with Discretion or prior permission in case of emergency or any eventuality.

Emergency contact:

Contact name _____

Address _____

City _____ State _____ Zip _____

Phone _____ email _____

Relation to Client: _____

Special needs/other information

Please check all that apply:

- ☐ Hearing impaired ☐ Visually impaired
- ☐ Physically impaired ☐ Wheelchair bound
- ☐ Developmentally disabled
- ☐ Recently released from incarceration
- ☐ Recently incarcerated
- ☐ Chronically mentally ill
- ☐ Other need _____
- ☐ None

SIGNATURES

WA STAFF: _____

CLIENT/GUARDIAN: _____

OFFICE USE ONLY: ALL INFORMATION ON PAGE VERIFIED & UPDATED

1ST Review Date:_____ 2nd Review Date:_____ WA STAFF:____