Email completed intake form & your incident report to intakes@cacofaiken.org or Fax them to (803) 644-7233

CLIENT INTAKE FORM

Please indicate your available dates/times for the next week(s):

Date ____	**Mon.**	**9:30**	**10:30**	**1:00**	**____**	**Thurs.**	**9:30**	**10:30**	**1:00**
____	**Tues.**	**9:30**	**10:30**	**1:00**	**____**	**Fri.**	**9:30**	**10:30**	**1:00**
____	**Wed.**	**9:30**	**10:30**	**1:00**					
ex. __5/2_	**Mon.**	**(9:30)**	**10:30**	**1:00**	**_5/5_**	**Thurs.**	**9:30**	**(10:30)**	**(1:00)**

Child's Name:________________________ **SS#**____________________ **Date:**__________

DOB:______________ **Age**: ___________ **Sex**: ____________ **Race**:____________________

Source of Referral: ____

Do client or custodians have special needs we need to be aware of? (i.e. disability, language barrier, etc.)

No ___ Yes___ Explain ____

Contact Person for Scheduling: __________________ **Relationship to Child:** ____________________

Address: ____

Phone: (Home) ___________**(Work)** ___________ **(Other)** ___________________________

Mother:______________________________ **Father:** ___________________________________

Mother's Address & Phone: ____

Father's Address & Phone: ____

Alleged Offender: __________________ **Relationship to Client:** ______________________________

Offender Age: ________ **Offender Race:** ________ **Date of Last Allegations:** ____________________

Brief Summary of Allegations:____

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What were the circumstances of the disclosure?

- ☐ Child disclosed/revealed abuse
- ☐ Child displayed behaviors
- ☐ Abuse was witnessed
- ☐ Results of medical exam
- ☐ Perpetrator confession
- ☐ Other

Previous services given by other agencies?

Yes or No

If yes, please describe: ____________________________________

____

Has this incident been cross-reported?

Yes or No

Reminder: All sexual abuse cases should be cross-reported

Agencies involved and Contacts:

DSS Contact:______________________________ Phone & Fax______________________________

LE Contact:______________________________ Phone & Fax______________________________

LE Case # ____ Report Date:____________________

Prior Medical Exam?__________ Location: __________________ Date of Exam: ______________