AGAPE COMMUNITY SERVICES

Intake Form

Name:_____ Date: / /

Address: _____

_____ Tel. # ( ) -

My area of concern is: _____

_____

Have you received any services from the ACS for this issue before? Yes: _____ No: _____

If yes, please answer the following questions:

Date of service:_____

Counselor name:_____

The outcome: _____

How long has this problem been going on for?

_____

What, if any, actions have you taken to try to solve this problem? _____

_____

What are the changes that you are looking to accomplish? How can the ACS help you accomplish them?

_____

_____

The counselor's comments:_____

_____

_____

Counselor's name: _____ Date: _____

Assessment

1- What is the problem in your point of view?

_____

_____

_____

2- How long has this been going on for?

_____

_____

3- Who else is involved in this problem?

_____

_____

4- What did you do to solve the problem?

_____

_____

_____

5- What was the outcome?

_____

_____

_____

6- What changes are you looking to accomplish?

_____

_____

_____

7- Medical history: (medication, surgery, hospitalization……)

_____

_____

_____

8- Family History (relationship among the family, smoking, drinking, marital issues, unemployment)

_____

_____

_____

_____

_____

9- Counselor recommendations:

_____

_____

_____

10- Referral to one of the following: (For the counselor to check all appropriate box(s))

_____ Referral to the school system

_____ Outpatient counseling

_____ Meeting with the family member who is involved in the presented problem

_____ Referral to MD for physical exam.

_____ Referral for meds

_____ Consider for ACS Housing Assistance (if meet the requirements)

_____ Other (please specify) _____

Counselor Name: _____ **Date:** _____/_____/_____