Youth & Family Resource Center, Inc.
Request For Services/Screening/Demographics

*Office use: YFRC Number:_____ JOLTS Number: _____ CW KK Number: _____ Tribal Welfare Number: _____	Referral Reason: _____ Referral Source: _____ School Status: _____	Custody Intake: _____ Custody: _____ Custody Type: _____ Custody Discharge: _____

Date:_____ Time:_____

Have you received services here before? ☐ Yes ☐ No

If yes, what type of service was provided:_____

IDENTIFYING INFORMATION/ SOCIAL STATUS

Source of Information: _____

Referred by: _____ **Relationship to Client**: _____

Last Name: _____ **First Name**: _____ **MI**: _____

SSN: _____-_____-_____ **DOB**: _____/____/_____ **Age:** _____ **Gender:** ☐ M ☐ F

Address: _____

City: _____**State**: OK **Zip**: _____ **Email:**_____

Phone: _____ Can we leave a voicemail? ☐ Yes ☐ No **Work Phone:** _____

Race: ☐ Caucasian ☐ African American ☐ Native American, if yes what tribe Click here to enter text.
☐ Asian ☐ Australian/New Zealand ☐ Caribbean-Islander ☐ Central American ☐ Eskimo ☐ European
☐ Hispanic/Latino ☐ Mixed ☐ Native American ☐ North American ☐ Pacific-Islander ☐ South African
☐ South American ☐ Sub-Saharan African ☐ Other

Are you required to register as a sex offender? ☐ Yes ☐ No

Legal Custody (if child): ☐ DHS Custody (Temporary, Emergency, or Permanent) ☐ OJA Custody
☐ Detention/ Probation ☐ Parental ☐ N/A ☐ Other_____

(DHS, OJA, PO) **Worker Name**: _____ Phone: _____ **County**:_____

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Other:

Education: Name of school attending/last attended: _____ **Grade:**_____

Emergency Contact (If client is under 18 or under legal guardianship, list parent/guardian)

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: OK Zip: _____

Phone: _____ Relationship:_____

Client's Name: _____ Case Number: _____

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Parent/Legal Guardian: _____

Employer: _____ **Work Phone:** _____

Spouse: _____ **Phone Number:** _____

Name of Child: _____ **D.O.B:** _____

Name of Child: _____ **D.O.B:** _____

Name of Child: _____ **D.O.B:** _____

Special Instructions (re: allergies, medical diagnosis, etc.): _____

Health Care Resources:

☐ Private Insurance ☐ Public Insurance (Medicaid) ☐ None ☐ SSI ☐ SSDI ☐ Medicare ☐ Indian Health Services

Provider: _____ **Policy/Medicaid Number**: _____

Policy Holder (Cite name as it appears on the insurance card): _____

Other Information:_____

If uninsured, does client appear to meet Medicaid eligibility requirements? ☐ Yes ☐ No ☐N/A

If uninsured, does client and/or family need assistance filing for Medicaid? ☐ Yes ☐ No ☐ N/A

Advanced Directive

Do you have an Advanced Directive for Health Care? ☐ Yes ☐ No

Would you like to have a copy on file with our agency? ☐ Yes ☐ No

If No, would you like to complete an Advanced Directive to file with YFRC? ☐ Yes ☐ No

Income:

Source of Income: _____ Yearly Amount: $_____

Source of Income: _____ Yearly Amount: $_____

Number of people contributing and/or depending upon "Annual Income" Above: _____

SERVICE(S) REQUESTED:		***OTHER NEEDS OR CONCERNS***
☐ Counseling Services	☐ Children of Divorce Classes	☐ Abuse of any kind (child/adult)
☐ Child Parent Relationship Therapy (Parenting)	☐ Emergency Shelter (17- under)	☐ Behavioral Concerns (list)
☐ Premarital/Couples Counseling	☐ Crisis Intervention	☐ Thoughts of harming self
☐ Community Service	☐ Other:	☐ Thoughts of harming others

Client's Name: _____ Case Number: _____

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Has the person you are seeking services for:

Experienced a traumatic event, natural disaster, accident, injury, loss of a loved one?	☐ Yes	☐ No
Ever been hit, slapped, kicked, emotionally or sexually hurt, or threatened?	☐ Yes	☐ No
Currently addicted to and/or missing any prescription medication or other over the counter products?	☐ Yes	☐ No
Been addicted to or misused any prescription medication or over the counter products?	☐ Yes	☐ No
Currently using alcohol or other drugs?	☐ Yes	☐ No
History of using alcohol or drugs?	☐ Yes	☐ No
Had thoughts that they would be better off dead or of hurting themselves within the past 2 weeks?	☐ Yes	☐ No
Ever done anything, started to do anything, or prepared to do anything to end their life?*	☐ Yes	☐ No
*If yes, was this this within the past three months?	☐ Yes	☐ No

Reason for seeking services:

_____

_____

_____

_____

Information received by: _____ **Date**:_____

_____ _____
Client's Signature Date

_____ _____
Parent/Guardian's Signature (Required if client under age 18) Date

_____ _____
Signature of Treatment Provider/ Credentials Date

_____ _____
Supervisor (IF applicable) Date

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FOR STAFF ONLY

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Services requested: ☐ Outpatient Services ☐ CARS ☐ CAB ☐ Community Service

Comments: _____

_____

_____

_____

_____

Appointment Date: _____ Time: _____

Contact Log:		
First contact:	Second Contact:	Third Contact:

Client's Name: _____ Case Number: _____