



Youth & Family Resource Center, Inc.  
Request For Services

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:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

Can we leave a voicemail?  Yes  No

Can we text you to schedule the intake appointment?  Yes  No

**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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**Secondary Emergency Contact**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: OK Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**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

Would you like more information regarding Advanced Directives?  Yes  No

Client's Name: \_\_\_\_\_ Case Number: \_\_\_\_\_



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<b>SERVICE(S) REQUESTED:</b>		<b>OTHER NEEDS OR CONCERNS</b>
<input type="checkbox"/> Therapy Services <input type="checkbox"/> Family Therapy	<input type="checkbox"/> Children in Between (Co-Parenting) Classes	<input type="checkbox"/> Abuse of any kind (child/adult)
<input type="checkbox"/> Parent Child Interaction Therapy (PCIT)	<input type="checkbox"/> Emergency Shelter (17- under)	<input type="checkbox"/> Behavioral Concerns (list)
<input type="checkbox"/> Parenting Class	<input type="checkbox"/> Crisis Intervention	<input type="checkbox"/> Thoughts of harming self
<input type="checkbox"/> Community Service	<input type="checkbox"/> Supervised Visits	<input type="checkbox"/> Thoughts of harming others
<input type="checkbox"/> In Step/FTOP	<input type="checkbox"/> Making Sense of Your Worth	<input type="checkbox"/> Court Involvement
<input type="checkbox"/> Case Management (assistance with food, transportation, housing, other resources)	<input type="checkbox"/> Community at Risk Services (CARS)	<input type="checkbox"/> Other:

**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:**

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Client's Name: \_\_\_\_\_ Case Number: \_\_\_\_\_



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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

\*\*\*\*\*

**FOR STAFF ONLY**

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<u>*Office use:</u> YFRC Number: _____ JOLTS Number: _____	Referral Reason: _____ Referral Source: _____ School Status: _____	Custody: _____ Custody Type: _____
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Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_

Client's Name: \_\_\_\_\_ Case Number: \_\_\_\_\_