

SOTM INTAKE FACE SHEET



Please answer the following questions as fully as possible. The information will assist your case manager to better serve you.

Court Ordered

YES No

Please check one box: First-time to SOTM Returning - last time with SOTM _____

I would also like to participate in (*Check all that applies*):

Mentor YSOTM Training _____

Counseling Life Skills Program _____

Date _____ Referral Source: _____

Last Name _____ First Name _____ Mid _____

Address _____

(Street)

City _____ State _____ Zip _____

Phone: (*Hm*) _____ (*Cell*) _____ (*Wrk*) _____

E-mail Address _____ County _____

Date of Birth: _____ Age: _____ Gender: _____ Race: _____

Church Home _____ Pastor _____ (*if any*)

Marital Status _____ Number of Children _____

Medications currently taking _____

What is your occupation? _____

How did you learn of SOTM, Inc. _____

WHAT IS HAPPENING WITH SELF/FAMILY? (*Check all that applies*) This information is needed in order to properly serve you with resources and referrals.

- Family Violence Family Conflict Substance Abuse Truancy Suicide/Homicide Ideation
 Suicide Attempt CPS Involvement Past Psychiatric Hospitalizations Involvement in Juvenile Justice System
 Adult Probation Parent/Caregiver Abuse or Neglect Behavioral Problems at Home /School
 Behavioral Problems Emotional Abuse Physical Abuse Sexual Abuse Sexual Orientation
 Homeless Runaway Incarcerated Parent Insufficient Income Pregnancy
 Other: _____

In the event of an emergency, please contact _____

Relationship _____ Phone () _____

Date form completed: _____ Person Completing intake: _____