

Randolph Behavioral Health Services  
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## CHILD INTAKE FORM

**Date:**

**GENERAL INFORMATION:** Please provide the following information and answer the questions below. Information you provide is confidential and won't be released to any institution without your approval.

INTAKE METHOD:	PHONE	FAX	EMAIL	COURT MANDATED:	YES	No
<b>REFERRAL SOURCE (NAME OR AGENCY):</b>						
<b>PHONE NUMBER:</b>						
<b>Client Information</b>						
<b>Name:</b>			<b>Date of Birth:</b>		<b>Gender: Male Female</b>	
<b>Address:</b>		<b>Apartment Number:</b>		<b>(If involved with DCF)</b>		
<b>City &amp; State:</b>		<b>School:</b>		<b>Social Worker:</b>		
<b>Zip Code:</b>		<b>IEP?</b>		<b>Phone Number:</b>		
<b>Race/Ethnicity:</b>			<b>Preferred Language:</b>			
<b>Phone Number:</b>			<b>Email (for scheduling):</b>			
<b>May we leave a message?</b>						
<b>Emergency Contact:</b>			<b>Phone Number:</b>			
<b>Insurance Information</b>						
<b>Insurance:</b>			<b>Member ID:</b>			
<b>Subscriber's Name:</b>			<b>Subscriber's Date of Birth:</b>			
<b>Reason for Referral (Presenting Issue)</b>						
<ol style="list-style-type: none"> <li>1. Are you seeking counseling or medication management?</li>   <li>2. Please explain why in a few words:</li>   <li>3. How long have you been dealing with your situation?</li> </ol>						

