COMOX VALLEY FAMILY SERVICES SEXUAL ABUSE INTERVENTION PROGRAM (SAIP)

CLIENT INTAKE/REFERRAL FORM (VICTIMS)

****PLEASE PRINT CLEARLY****

CHILD/YOUTH NAME: _____________ **DOB:**_______________ **AGE:** _____ **SEX:**_________

REFERRAL DATE: _______________________ **THERAPY START DATE:**_____________________

COUNSELLOR: _________________________

CLIENT ADDRESS: ____

CAREGIVER NAME:____________________ **RELATIONSHIP TO CLIENT:**______________________

MARITAL STATUS: Married Common Law Separated Divorced Widowed Single

Do you have sole legal custody of your child? YES NO

PHONE # (HOME): ____________________ **(WORK/CELL):**__________________________

MAY WE LEAVE MESSAGES AT YOUR PHONE NUMBER? _________

EMAIL (OPTIONAL) -_______________________________

EMERGENCY CONTACT: ___________________________ **PHONE #:** _____________________

ALLERGY/MEDICAL INFORMATION: ____

CURRENT FAMILY INFORMATION

	Mother	Father	Other Caregiver(s)
Name			
Occupation			

SIBLINGS

	Oldest	Next	Next	At home/away	Biological/Step
Name					
Gender					
Birth date					
Age					

CURRENT EDUCATION/LAST SCHOOL ATTENDED

School	Grade	Teacher	School Counsellor	Performance

OTHER PROFESSIONALS INVOLVED WITH FAMILY:

____

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Who made the referral? ____________________________

Is client/family aware of this referral? Yes _____ No _____

Initial contact with client made (Date): ___________________________

Is Criminal Injury Compensation available? Yes_____ No_____

Details of Abuse:

Abuse type: ___ rape/assault ___ incest ___ molestation ___ exposure ____ unknown

Name of alleged offender: ____________________ Age of offender: ________

Relationship to client: _________________

When did abuse occur (age of client at time): ______

Frequency/Duration of abuse: __________________________

Status of child's contact with the offender: ____________________ __

When did disclosure occur: ____

Who did child disclose to: _______________________________________

What information was disclosed (any force or threat?):

Indicators/Presenting Concerning Behaviours:

Urgent issues (self-harm, suicidal ideation):

Additional Information (restraining order, other abuse, any previous counselling for any reason):

Status of Investigation: . ____

File #:_____________ Police/RCMP:____

Court Date: ____

Social Worker: _______________________________ Phone: ____________________________________

**Please attach PREVIOUS ASSESSMENTS OR REPORTS which may be relevant. **