Wchan Organization for Victims of Human Rights Violations

Trauma Rehabilitation & Training Center

Client Intake Form

Project Name: _____ Case Number: _____

Intake Worker: _____

Date: _____ Time: _____

Name: _____ Sex: _____ Age: _____

DOB: _____ Place of birth: _____

Address: _____

Telephone number (s): _____ Mobile Number: _____

In case of emergency, contact number and name: _____ (relationship to you) _____

Ethnicity: _____ Religion: _____

Education: _____ Employed: Yes No

Occupation: _____ Ex - Occupation: _____

Marital Status: _____ Number of children: _____

Date of Arrested: _____ Duration in Detention: _____ Period of charge: _____

Type of case:

☐ Torture: By: Year:

☐ Family member of torture: By: Year:

☐ Trauma: Type: Year:

☐ GBV: By: Year:

Type of GBV:

Family mapping:

Chief complaints:

Duration:

HISTORY OF PSYCHIATRIC TREATMENT:

Have you ever being seen a psychiatrist? Yes No

If yes: What was your complaint?

Have you being admitted to the psychiatric hospital? Yes No

Give details:

Type of services needed:

☐ Individual ☐ Family: ☐ Group: ☐ Psychiatrist: ☐ Advocacy:

☐ Case Management ☐ Other

Interviewer's remarks (please explain trauma history/events**):**