Office Use
Collaborate
#_____
Packet Sent: □ Yes □ No
Date: _____

FIRST LIGHT

INTAKE SHEET | Client Information

Today's Date: _____
Start Time: _____ □AM □PM **End Time**: _____ □AM □PM **Total Minutes of Service**: _____
Date of Assault (if w/in last year): _____ ***OR*** **Assault occurred**: □1-3 yrs. ago □3-7 yrs. ago □ 7+ yrs. ago
Person Taking Call: _____

CLIENT INFORMATION

We require the following information for the purposes of helping our staff use the most respectful language when addressing our clients, understanding our population better, and fulfilling our grant reporting requirements. Please help us serve you better by selecting the best answers to these questions. If you do not feel comfortable with the question, you may decline to answer it.

Last Name: _____ **First Name:** _____ **Middle Name:** _____
Age: _____ **Date of Birth:** _____
Pro-nouns: □She/Her □He/Him □They/Them □Other _____ □Decline to Answer
Gender Identity: □Male □Female □Trans Male □Trans Female □Gender nonconforming □Other □Decline to Answer
Race: □Black/African American □White □ Hispanic □Asian □American Indian □Other: _____
Do you have a disability? □ Yes □ No **If yes, please explain**: _____
Veteran? □Yes □No □Decline to Answer **Housing Status:** □Stable Housing □Homeless □Decline to Answer
Interpreter needed: □Yes □No If yes, what language? _____
What is the safest way for Foothills Alliance to contract you?
□ E-mail □ Phone Call □ Mail □ Do not contact me □ Declined to give contact information
E-mail Address: _____
Mailing Address: _____
City: _____ **State**: _____ **Zip**: _____ **County**: _____
Do you have a different physical address? □Yes □No □No physical address
Physical Address: _____
City: _____ **State**: _____ **Zip**: _____ **County**: _____
Telephone: Home _____ Cell _____ Work _____
Marital Status: □Engaged □Married □Single, Never Married □Separated □Divorced □Partner □Widowed
Have you ever been to First Light before? □Yes □No When? _____
If minor, Guardian Name: _____ **Relationship**: _____
School: _____ **Status:** □Full-time □Part-time
In case of emergency, who may we contact? _____ **Relationship** _____
Address _____ **Phone** _____

First Light staff and volunteers are bound by strict confidentiality rules. We share client information within the agency when necessary for treatment purposes. For the protection of our survivors and in accordance with SC law, we are required to report threats of self-harm and child abuse if the survivor is still under the age of 18. A full copy of our confidentiality policy can be found on our website.

OFFENDER INFORMATION

□ **Unknown Offender**

Name: _____ **Age**: _____ **Sex**: □Male □Female

Race: □Black/African American □White □ Hispanic □Asian □American Indian □Other: _____

Relationship to Survivor:

_____

Current address (if known):

_____

Has offender been prosecuted for your allegation? □Yes □No □Unknown □Case in Progress

INCIDENT INFORMATION

Assault Type (check all that may apply)**:**

□ Child Survivor of Abuse or Neglect
□ Child Survivor of Sexual Assault
□ Secondary Survivor of Sexual Assault/Abuse
□ Adult Survivor of Domestic Violence
□ Adult Survivor of Childhood Incest or Sexual Abuse
□ Adult Survivor of Sexual Assault

Survivor Statement of Facts (attach additional pages as necessary)**:**

_____

_____

_____

Do you have a prior history of sexual assault/abuse? □Yes □No □Not Sure **If yes, please explain**:

_____

Is there a concern about the use of date rape drugs? □Yes □No

Were any weapons used? □Yes □No If yes, please explain:

_____

Was medical care obtained for sexual assault/abuse? □Yes □No □Not Sure

Hospital: □AnMed □Oconee □CAC □Other (specify): _____

Was rape kit completed? □Yes, and I gave my information □Yes, and it was anonymous □No

Name of Physician: _____ **Name of Nurse:** _____

Was clothing provided by Anderson or Oconee hospital staff or a Foothills Volunteer Advocate? □Yes □No

Was law enforcement notified? □Yes □No **If yes, which agency?** _____

Name of Officer/Investigator: _____ **Case #:** _____

Was DSS notified? □Yes □No □Not Sure **Name of DSS Contact:** _____

If yes, which county? □Anderson □Oconee □Other (please specify): _____

IS THIS CLIENT IN CRISIS?

In the past three months have you:

□ Had any thoughts about hurting yourself or someone else? If yes, when was the last time? _____
□ Had thoughts about ending your life? If yes, when was the last incident? _____
□ Had thoughts about dying? If yes, when was the last time? _____
□ Hurt yourself? If yes, how and when was the last time? _____
□ Hurt yourself with the plan to end your life? If yes, when was the last incident? _____

If one of these boxes is checked, follow the Columbia Protocol and call 911 if necessary.
If 911 is not required by that protocol, remain on the line and connect with a clinician for an emergency coping session.
If after business hours, call 911.

Type of Call: □Crisis Hotline Call □ER Visit □Referral □Website Inquiry

Services Requested: □Counseling □CAC Referral □ER accompaniment □Housing □Financial Assistance □Food □Transportation □Other resources _____