TN Department of Children's Services

Initial Intake, Placement and Well-Being Information and History

Child Name: _____ **Date of Birth:** _____ **Person ID:** _____

Initiated By: _____ **Title:** _____ **Date:** _____

Revised By: _____ **Title:** _____ **Date:** _____

Person Providing Information to DCS: _____ **Relationship to Child/Youth:** _____

Current Insurance Coverage: ☐ Yes ☐ No ☐ Unknown

If yes, provide details: _____

Child/Youth Information

Name of Child/Youth: _____ **Email Address:** _____ **SSN:** _____

Date of Birth: _____ **Hispanic:** ☐ Yes ☐ No **U.S. Citizen:** ☐ Yes ☐ No

Sex: _____ **Race:** _____ *Provide Birth Certificate Verification*

Is Child/Youth of Native American Descent? ☐ Yes ☐ No ☐ Unable to Determine **If yes, Tribal Affiliation:** _____

Child/Youth's Marital Status ☐ Never Married ☐ Divorced ☐ Widowed ☐ Married ☐ Separated

Has Youth been placed in out of home care prior to this custody episode? ☐ Yes ☐ No

If yes, please list dates and placements: _____

Current Description of the Child/Youth

Physical Description Date: _____ **Primary Language Spoken:** _____

Height: _____ **Weight:** _____ **Hair Color:** _____ **Eye Color:** _____

Identifying Marks or Tattoos: _____ **Religion:** _____

Special Needs/Disabilities: _____

Special Medical Equipment: _____

Scheduled Appointments:
(Date, Providers, Location, Type of Appt.)

Allergies: ☐ Yes ☐ No

Allergic to: **Medication:** _____ **Describe Reaction:** _____

Food: _____ **Describe reaction:** _____

Child Name: _____ **Date of Birth:** _____ **Person ID:** _____

Insect Sting: _____ **Describe Reaction:** _____

Other: _____ **Describe Reaction:** _____

Medical modified/Religious diet? ☐ Yes ☐ No

If yes, describe: _____

Medications: Prescribed and Over the Counter

Current medications

(Name, Route, Frequency, Dosage & Days of Meds Left)

Are medications given in school? ☐ Yes ☐ No

Which meds? _____

Consent signed for psychotropic meds: ☐ Yes ☐ No ☐ N/A **Next med appointment:** _____

Has Foster Parent received medication: ☐ Yes ☐ No

Explain: _____

Health History of Child *(Explain any items checked Now/Past in "Comments" Section.)*

No	Now	Past		No	Now	Past		No	Now	Past	
☐	☐	☐	Birth defects	☐	☐	☐	Gastrointestinal problems	☐	☐	☐	Asthma/Respiratory Disease
☐	☐	☐	Vision problems	☐	☐	☐	Kidney/urinary problems	☐	☐	☐	Heart murmur
☐	☐	☐	Hearing problems	☐	☐	☐	Cancer	☐	☐	☐	Heart problems
☐	☐	☐	Skin problems	☐	☐	☐	Tuberculosis *(TB)*	☐	☐	☐	High blood pressure
☐	☐	☐	Head injuries	☐	☐	☐	_____	☐	☐	☐	Physical disabilities
☐	☐	☐	Sickle cell disease	☐	☐	☐	Developmental delays	☐	☐	☐	Accidents *(Describe Below)*
☐	☐	☐	Anemia/blood disorder	☐	☐	☐	Learning disability	☐	☐	☐	Hospitalizations *(Describe Below)*
☐	☐	☐	Epilepsy/seizures	☐	☐	☐	Sleep problems	☐	☐	☐	Surgeries *(Describe Below)*
☐	☐	☐	Bedwetting	☐	☐	☐	Incontinence: _____	☐	☐	☐	Problems with anesthesia
☐	☐	☐	Diabetes	☐	☐	☐	Other medical *(Describe Below)*	☐	☐	☐	Other developmental disabilities

Child Name: _____ **Date of Birth:** _____ **Person ID:** _____

Child/Youth is currently hospitalized: ☐ Yes ☐ No

If yes, where and why:

Comments/Additional health information/ongoing health related services:

Childhood Illnesses

No	Yes	Approx. Date		No	Yes	Approx. Date	
☐	☐	_____	Measles	☐	☐	_____	Chicken Pox
☐	☐	_____	German	☐	☐	_____	Scarlet Fever
☐	☐	_____	Measles Mumps	☐	☐	_____	Rheumatic Fever

Trauma Screening

Indicate *known* history of abuse/adverse experiences. Explain any yes answers in "Comments" section.

No	Yes		No	Yes	
☐	☐	Neglect	☐	☐	Domestic Violence
☐	☐	Physical Assault / Abuse	☐	☐	School Violence
☐	☐	Sexual Assault / Abuse	☐	☐	Community Violence
☐	☐	Emotional Abuse	☐	☐	Extreme Interpersonal Violence
☐	☐	Traumatic loss / Separation	☐	☐	Natural Disaster
☐	☐	Extended Illness/Medical Trauma	☐	☐	Impaired Caregiver *(Substance Abuse/Mental Illness)*
☐	☐	Serious Injury	☐	☐	Other trauma, describe:

Child Name: _____ Date of Birth: _____ Person ID: _____

Has abuse been reported? ◯ Yes ◯ No *If no, call CPS 877-237-0026*

Comments/Additional health information:

Behavioral/Mental Health History

No	Now	Past		If yes, Describe:
☐	☐	☐	Intense anger	
☐	☐	☐	Oppositional	
☐	☐	☐	Negative Peer Association	
☐	☐	☐	Extreme Attention Seeking	
☐	☐	☐	Makes False Statements	
☐	☐	☐	School Difficulties	
☐	☐	☐	Damage of Property	
☐	☐	☐	Habitual Lying	
☐	☐	☐	Stool Smearing	

Child Name: _____ Date of Birth: _____ Person ID: _____

Behavioral/Mental Health History

No	Now	Past		If yes, Describe:
☐	☐	☐	Stealing	
☐	☐	☐	Runaway	
☐	☐	☐	Hoarding	
☐	☐	☐	Problems with concentration and attention	
☐	☐	☐	Excessive Hyperactivity/ does not respond to safety instructions	
☐	☐	☐	Requires Constant Supervision	
☐	☐	☐	Anxiety	
☐	☐	☐	Depression	
☐	☐	☐	Seeing or hearing things that aren't there	
☐	☐	☐	Fire-setting	

Child Name: _____ Date of Birth: _____ Person ID: _____

Behavioral/Mental Health History

No	Now	Past		If yes, Describe:
☐	☐	☐	Animal cruelty	
☐	☐	☐	Animal fear	
☐	☐	☐	Self-injurious behavior/Other Self Harm	
☐	☐	☐	Aggressive, dangerous or destructive behaviors	
☐	☐	☐	Sexual aggression	
☐	☐	☐	Had homicidal thoughts	
☐	☐	☐	Had suicidal thoughts	
☐	☐	☐	Attempted suicide	
☐	☐	☐	Had other mental health or behavioral problems	
☐	☐	☐	Other mental health diagnosis	

Child Name: _____ **Date of Birth:** _____ **Person ID:** _____

Has the Child/Youth received counseling or therapy? _____

If yes, where?

Has the Child/Youth had a Psychological Evaluation: _____

If yes, diagnosis, when, where?

Has the Child/Youth been hospitalized for mental health problems / acute hospitalization? _____

If yes, diagnosis, when, where?

Has the Child/Youth/Family received in-home services? _____

If yes, when, where?

Has the Child/Youth previously been placed in a residential treatment facility? _____

If yes, when, where?

Alcohol/Drug Abuse History

No	Now	Past	Frequency *(X per day/week/month)*		No	Now	Past	Frequency *(X per day/week/month)*	
☐	☐	☐	_____	Alcohol	☐	☐	☐	_____	Methamphetamine
☐	☐	☐	_____	Tobacco	☐	☐	☐	_____	Hallucinogens
☐	☐	☐	_____	Vapor/E-Cigarettes	☐	☐	☐	_____	Steroids
☐	☐	☐	_____	Marijuana	☐	☐	☐	_____	Huffing
☐	☐	☐	_____	Narcotics	☐	☐	☐	_____	Ecstasy
☐	☐	☐	_____	Stimulants	☐	☐	☐	_____	Street drugs, unknown
☐	☐	☐	_____	Prescription drugs prescribed for another, specify: _____					
☐	☐	☐	_____	Over-the-counter medication, specify: _____					
☐	☐	☐	_____	Other, specify: _____					

Child Name: _____ **Date of Birth:** _____ **Person ID:** _____

Has child been identified as high risk? ☐ Yes ☐ No

Has a Safety Plan been completed on child identified as high risk? ☐ Yes ☐ No

Birth History *(For all children)*

Birth Weight: _____ **Birth Length:** _____

☐ **Full term** ☐ **Premature birth** *(<36 weeks)* _____ Weeks

Did mother receive prenatal care: ☐ Yes ☐ No

Month of pregnancy for 1st prenatal visit: _____

Pregnancy/Birth Complications: _____

Was there prenatal substance abuse: ☐ Yes ☐ No

Substance and frequency: _____

Birth hospital and location: _____

Minor Female

Age of 1st period: _____ **Date of Last Period:** _____

Pregnancies #: _____ **Live Births #:** _____ **Full Term:** _____

Miscarriages #: _____ **Abortions #:** _____ **Premature** *(# weeks)* _____

Currently Pregnant: ☐ Yes ☐ No **If yes, Due Date:** _____

Gender and Sexual Identity

Does the Child/Youth identify him/herself as gay, lesbian, transgender, or intersex? ☐ Yes ☐ No

If yes, describe answer:

Child Name: _____ **Date of Birth:** _____ **Person ID:** _____

Sexual Activity

Is child sexually active? ☐ Yes ☐ No **Use birth control?** ☐ Yes ☐ No **Method:** _____

Dating Violence

Has Child/Youth experienced controlling, abusive or aggressive behavior in a dating relationship? ☐ Yes ☐ No

If yes, explain:

Medical

Does the Child/Youth have a regular medical provider? *(Pediatrician, family doctor, etc.)* ☐ Yes ☐ No

If yes, name of medical provider: _____ **Date of last visit:** _____

Immunizations

Are immunizations up-to-date: ☐ Yes ☐ No **Is the immunization record available?** ☐ Yes ☐ No

Religious/medical exemption? ☐ Yes ☐ No *(Parent/guardian must provide a notarized statement.)*

Dental

Does the Child/Youth have a regular dental provider? ☐ Yes ☐ No **Does the Child/Youth wear braces?** ☐ Yes ☐ No

If yes, name of dental provider: _____ **Date of last exam:** _____

If braces, name of orthodontist: _____ **Date of last exam:** _____

Vision

Does the Child/Youth wear glasses? ☐ Yes ☐ No **Does the Child/Youth wear contacts?** ☐ Yes ☐ No

If yes, name of vision provider: _____ **Date of last visit:** _____

This concludes the Well-Being Section

Child Name: _____ **Date of Birth:** _____ **Person ID:** _____

This information does not go to Health Care Provider

Education and Independent Living

Student graduated High school: ☐ Yes ☐ No ☐ GED ☐ HiSet ☐ Student Home Schooled

School Name: _____ **School City:** _____ **School County:** _____

Student's Age: _____ **Current Grade:** _____

Student receives special education services: ☐ Yes ☐ No

If yes, name the disability: _____

No	Yes	
☐	☐	Is the student taking GED classes?
☐	☐	Does the student have a history of skipping school?
☐	☐	Is the student in an alternative school?
☐	☐	Is the student serving a zero tolerance expulsion (drugs, weapons and/or assault)?
☐	☐	Is the student serving a suspension for issues other than zero tolerance?

If yes, what is the reason and duration of suspension?

_____

Student strengths & Areas needing Improvement *(Check all that apply.)*

_____ Mathematics

_____ Reading

_____ Athletics

_____ Attendance in school

_____ Other, specify: _____

_____ Other, specify: _____

Other things you would like to share regarding your student's schooling.

Child Name: _____ **Date of Birth:** _____ **Person ID:** _____

Presenting and Previous Court Actions on Youth *(Unruly/Delinquent Youth Only)*

Current Dispositional Information: _____

Disposition Judge: _____ **Special Judge:** _____

Current Disposition Court: _____

Current Disposition Decision: _____

Have you been or are you currently on probation? ☐ Yes ☐ No **If yes, where:** _____

Defense Attorney: _____

Current Adjudication Type: _____ **Current Adjudication Date:** _____

Adjudicated Charge Current and Previous	Date Occurred	Disposition Date	Disposition

Pending Charges	Court Date Set		Date *(If yes)*
	☐ Yes	☐ No	
	☐ Yes	☐ No	
	☐ Yes	☐ No	
	☐ Yes	☐ No	
	☐ Yes	☐ No	
	☐ Yes	☐ No	

Violation of Probation (VoP) or Violation of Valid Court Order (VVCO) *(Explain if applicable)*

Narrative

Child Name: _____ **Date of Birth:** _____ **Person ID:** _____

Legal/Probation Services Previously Offered to Child/Youth

Date	Type	Outcome

Safety *(Unruly/Delinquent Youth only)*

Maltreatment Allegations or Unruly Behaviors/Delinquency

Other *(Explain)*

Narrative

Strengths *(Signs of Safety)*

Risks, Needs and Concerns (Sign of Risk*)

Domestic Violence

Narrative

Strengths *(Signs of Safety)*

Risks, Needs and Concerns *(Sign of Risk*)*

**Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.*

TN Department of Children's Services

Initial Intake, Placement and Well-Being Information and History

Child Name: _____ **Date of Birth:** _____ **Person ID:** _____

FSW Name: _____ **Contact Number:** _____

Office Address: _____

City: _____ **State:** _____ **Zip:** _____

Supervisor: _____ **Contact Number:** _____

_____ _____

DCS / Provider Staff *Date*

I acknowledge receipt of the Intake, Placement, and Well-Being Information and History. I further acknowledge my legal duty to maintain confidentiality of this information and history and any additional information I may receive pursuant to Tennessee Code Annotated §37-2-415, The Foster Parent Rights Act.

_____ _____

Foster Parent *Date*

_____ _____

Foster Parent *Date*