Tennessee Department of Children's Services

Initial Intake, Placement and Well-Being Information and History

Child Name:		Child DOB:		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:		E-mail Address:		SSN:	

DOB:		Sex:		Race:		Hispanic:	☐ Yes ☐ No	U.S. Citizen:	☐ Yes ☐ No Provide Birth Certificate Verification

Is this Child/Youth Reported or Suspected to have Native American Heritage or Tribal Affiliation? If "Yes", make a referral to IICA team using the ICWA Referral to Cultural Affairs Team form.	☐ Yes ☐ No	If "Yes", indicate which parent or custodian, Tribe, and registration information:	

Child/Youth's Marital Status *(check one)*	☐ Never Married	☐ Divorced	☐ Widowed	☐ Married	☐ Separated

Has Youth been placed in out of home care prior to this custody episode? If yes please list dates and placements:	☐ Yes ☐ No

Current Description of the Child/Youth

Physical Description Date		Primary Language Spoken	

Height		Weight		Hair Color		Eye Color	

Religion:		Identifying Marks or Tattoos:	

Special Needs/Disabilities:	
Special Medical Equipment:	
Scheduled Appointments: (*date, provider, location, type of appt*)	

Child Name:		Child DOB:		Person ID:	

Allergies/Adverse Reactions:	☐ Yes ☐ No		
Medication:		Describe reaction:	
Food:		Describe reaction:	
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 meds 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	
☐	☐	☐	Birth defects	☐	☐	☐	Gastrointestinal problems
☐	☐	☐	Vision problems	☐	☐	☐	Kidney/urinary problems
☐	☐	☐	Hearing problems	☐	☐	☐	Hepatitis/liver problems
☐	☐	☐	Skin problems	☐	☐	☐	Cancer
☐	☐	☐	Head injuries	☐	☐	☐	Tuberculosis (TB)
☐	☐	☐	Headaches	☐	☐	☐	Autism/Asperger's (circle one)
☐	☐	☐	Sickle cell disease	☐	☐	☐	Developmental delays
☐	☐	☐	Anemia/blood disorder	☐	☐	☐	Learning disability
☐	☐	☐	Epilepsy/seizures	☐	☐	☐	Sleep problems
☐	☐	☐	Bedwetting	☐	☐	☐	Incontinence: ☐ Urine ☐ Stool
☐	☐	☐	Diabetes	☐	☐	☐	Other medical *(describe below)*
☐	☐	☐	Asthma/Respiratory Disease	☐	☐	☐	Accidents *(describe below)*
☐	☐	☐	Heart murmur	☐	☐	☐	Hospitalizations *(describe below)*
☐	☐	☐	Heart problems	☐	☐	☐	Surgeries *(describe below)*
☐	☐	☐	High blood pressure	☐	☐	☐	Problems with anesthesia
☐	☐	☐	Physical disabilities	☐	☐	☐	Other developmental disabilities

Child/Youth is currently hospitalized:	☐ Yes ☐ No	
If yes, where and why:		

Child Name:		Child DOB:		Person ID:	

Comments/Additional health information/ongoing health related services:

Childhood Illnesses

No	Yes	Approx date		No	Yes	Approx date	
☐	☐		Measles	☐	☐		Chicken pox
☐	☐		German measles	☐	☐		Scarlet fever
☐	☐		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:

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

Comments/Additional health information:

Child Strengths

Behavioral/Mental Health History

No	Now	Past	
☐	☐	☐	Intense anger, if yes, describe
☐	☐	☐	Oppositional, if yes, describe
☐	☐	☐	Negative Peer Association, if yes, describe
☐	☐	☐	Extreme Attention Seeking, if yes, describe
☐	☐	☐	Makes False Statements, if yes, describe
☐	☐	☐	School Difficulties, if yes, describe
☐	☐	☐	Damage of Property, if yes, describe
☐	☐	☐	Habitual Lying, if yes, describe
☐	☐	☐	Stool Smearing, if yes, describe
☐	☐	☐	Stealing, if yes, describe
☐	☐	☐	Runaway, if yes, describe
☐	☐	☐	Hoarding, if yes, describe
☐	☐	☐	Problems with concentration and attention, if yes, describe

☐	☐	☐	Excessive Hyperactivity/does not respond to safety instructions, if yes, describe
☐	☐	☐	Requires Constant Supervision, if yes describe
☐	☐	☐	Anxiety, if yes, describe
☐	☐	☐	Depression, if yes, describe
☐	☐	☐	Seeing or hearing things that aren't there, if yes, describe
☐	☐	☐	Fire-setting, if yes, describe
☐	☐	☐	Animal cruelty, if yes, describe
☐	☐	☐	Animal fear, if yes, describe
☐	☐	☐	Self-injurious behavior/Other Self Harm, if yes, describe
☐	☐	☐	Aggressive, dangerous or destructive behaviors, if yes, describe
☐	☐	☐	Sexual aggression, if yes, describe
☐	☐	☐	Had homicidal thoughts, if yes, describe
☐	☐	☐	Had suicidal thoughts, if yes, describe
☐	☐	☐	Attempted suicide If yes, describe
☐	☐	☐	Had other mental health or behavioral problems, if yes, describe
☐	☐	☐	Other mental health diagnosis, if yes, describe

Has the Child/Youth received counseling or therapy?	☐ Yes ☐ No
If yes, where?	
Has the Child/Youth had a Psychological Evaluation:	☐ Yes ☐ No
If yes, diagnosis, when, where?	

Has the Child/Youth been hospitalized for mental health problems/acute hospitalization?	☐ Yes ☐ No
If yes, diagnosis, when, where?	

Has the Child/Youth/Family received in-home services?	☐ Yes ☐ No
If yes, when, where?	

Has the Child/Youth previously been placed in a residential treatment facility?	☐ Yes ☐ No
If yes, when, where?	

Alcohol/Drug Abuse History

No	Now	Past	Frequency (Xs per day/week/month)	
☐	☐	☐		Alcohol
☐	☐	☐		Tobacco smoke/chew *(circle one or both)*
☐	☐	☐		E-cigarettes/vapor cigarettes
☐	☐	☐		Marijuana

Child Name:		Child DOB:		Person ID:	

☐	☐	☐		Narcotics
☐	☐	☐		Stimulants
☐	☐	☐		Methamphetamine
☐	☐	☐		Hallucinogens
☐	☐	☐		Steroids
☐	☐	☐		Huffing
☐	☐	☐		Ecstasy
☐	☐	☐		Street drugs, unknown
☐	☐	☐		Prescription drugs prescribed for another, specify:
☐	☐	☐		Over-the-counter medication, specify:
☐	☐	☐		Other, specify:

Additional Comments:

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

Birth History (for all children)

Birth Weight:		**Birth Length:**		☐ **Full term or** ☐ **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**		**Premature (# weeks)**	
Miscarriages #		**Abortions #**		**Currently pregnant:**	☐ Yes ☐ No	**If yes, due date:**	

Does the youth have children? ☐ Yes ☐ No If yes, answer below questions:

Youth's Children's Names	DOB	In DCS Custody?	Male/ Female?	Race	Name of Person Child Lives with and Relationship	Name of Child's Other Parent	Contact Information of Other Parent
		Yes ☐ No ☐	Male ☐ Female ☐				
		Yes ☐ No ☐	Male ☐ Female ☐				
		Yes ☐ No ☐	Male ☐ Female ☐				

Does minor parent have visitation with their child(ren)? ☐ Yes ☐ No

Child Name:		Child DOB:		Person ID:	

If yes, list any visitation restrictions:	

Gender and Sexual Identity

Does the Child/Youth identify him/herself as gay, lesbian, transgender, or non-binary?	☐ Yes ☐ No
If yes, describe answer	

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.

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Child Name:		Child DOB:		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				
What school does the student attend? (name, city, 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 (check all that apply)	**Areas needing improvement (check all that apply)**
☐ Mathematics	☐ Mathematics
☐ Reading	☐ Reading
☐ Athletics	☐ Athletics
☐ Attendance in school	☐ Attendance in school
☐ Other, specify	☐ Other, specify

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

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

Current Dispositional Information			
Disposition Judge		**Special Judge**	
Current Disposition Court			
Current Disposition Decision		**Disposition Date**	
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**

Child Name:		Child DOB:		Person ID:	

Pending Charges	Court Date Set	Date (if yes)
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Violation of Probation (VOP) or Violation of Valid Court Order (VVCO) ***(explain if applicable)***

Narrative

Legal/Probation Services Previously Offered to Child/Youth

Date	Type	Outcome

Safety (Unruly/Delinquent Youth only)

A) Maltreatment Allegations or Unruly Behaviors/Delinquency

Other ***(explain)***	

Narrative

Strengths ***(Signs of Safety)***	

Risks, Needs and Concerns ***(Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.)***

B) Domestic Violence

Narrative

Strengths ***(Signs of Safety)***	

Risks, Needs and Concerns ***(Signs of Risk include aggressive behavior, arson, cruelty to animals, gang involvement, etc.)***

Child Name:		Child DOB:		Person ID:	

FSW Name		Contact #	
Office Address			
Supervisor		Contact #	

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*

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Child Name:		Child DOB:		Person ID:	

Do not provide this section to the Foster Parent or the Health Care Provider.

Has the child/Youth been adopted: ☐ Yes ☐ No: **Was the child/Youth in Permanent Guardianship:** ☐ Yes ☐ No

Receiving Adoption Assistance or Subsidized Permanent Guardianship: ☐ Yes ☐ No: If yes, **Amount:** _____
(If yes, immediately notify the Permanency Specialist, Child Welfare Benefits Counselor Regional and Central Office Fiscal Staff).

Adoption/Guardianship Completed by DCS: ☐ Yes ☐ No (If no List Name of the Agency)

Removal Date:			
New Placement:			
Date of Placement:			
Legal Custody Date:			
Removal County:		**Adjudication Type:** **Brief Description:**	☐ Dependent and Neglect ☐ Unruly ☐ Delinquent ☐ N/A
Removal Reason:	☐ Alcohol Abuse (Child); ☐ Alcohol Abuse (Parent); ☐ Caretaker Inability to Cope due to Illness or Other; ☐ Child's Disability; ☐ Drug Abuse (Child); ☐ Drug Abuse (Parent); ☐ Inadequate Housing; ☐ Incarceration of Parents; ☐ NAS Prosecution (only select upon DCS attorney instruction); ☐ Physical Abuse (alleged/reported); ☐ Relinquishment ☐ Sexual Abuse (alleged/reported); ☐ Truancy		

Removal Street Address							
City		**County**		**State**		**Zip Code**	
Kinship Exception Request							
Was KER approved?	☐ Yes ☐ No **If yes, by whom?:**						
Was the KER temporary or long term?	☐ **temporary** ☐ **long term**						
MSW Consult was completed with:							

Family Information

Both parents living?	☐ Yes ☐ No	**If no, date(s) of death:**	

Household income to determine IV-E eligibility: (including SS Benefits, SSI for child, AFDC, Foodstamps, Child Support, etc.) If additional supports are received, please indicate in whose name the payment/support is made.

Child/Youth Parent(s)/Caretaker(s)
Indicate Parent/Caregiver's Preferred Method for Receiving Documents

Birth Mother's Name					**Primary Caregiver**	☐ Yes	☐ No
Email Address					☐ Yes	☐ No	
Maiden Name		**Social Security No.**		**DOB**		**Message Contact #**	

Child Name:		Child DOB:		Person ID:	

Address		☐ Yes ☐ No	
City, State, Zip		**Contact #**	
Employer		**Address**	
City, State, Zip		**Contact #**	
Birth mother married when child/Youth was born?	☐ Yes ☐ No ☐ Unable to Determine		
Birth mother ever been married?	☐ Yes ☐ No ☐ Unable to Determine	**If so, where and to whom?**	
Birth mother ever been divorced?	☐ Yes ☐ No ☐ Unable to Determine	**If so, where and from whom?**	
Birth mother's race:			
Is there a father listed on the birth certificate?	☐ Yes ☐ No		
Has DNA testing ever been done?	☐ Yes ☐ No	**If so, what were the results and where was it done?**	
Has there ever been a legal father identified (either mother was married at the time of birth or a father has been legitimated through the court)?	☐ Yes ☐ No		
Legal Father's Name			
Email Address			
Social Security No.		**DOB**	
Address			
City, State, Zip			
Employer		**Address**	
City, State, Zip			
Legal Father's Race:			
Marital Status of Parents	☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Other**		
Putative/Alleged Father's Name			
Email Address			
Social Security No.		**DOB**	
Address			
City, State, Zip			
Employer		**Address**	
City, State, Zip			
Putative/Alleged Father's Race:			
Caregiver's Name *(if different from above)*			
Email Address			
Social Security No.		**DOB**	
Address			
City, State, Zip			
Employer		**Address**	

Child Name:		Child DOB:		Person ID:	

City, State, Zip	

Relative Contact Person For Child/Youth (other than parent)

Relationship	

Child/Youth Siblings:										In Custody
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No
Name		SSN		DOB		Sex		Race		☐ Yes ☐ No