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*)			
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)*	

Child Name:		**Child DOB:**		**Person ID:**	

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:**	

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:

Child Name:		**Child DOB:**		**Person ID:**	

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?					
Child Name:		**Child DOB:**		**Person ID:**	

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
☐	☐	☐		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:**	

Child Name:		**Child DOB:**		**Person ID:**	

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
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**

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)***

Child Name:		Child DOB:		Person ID:	

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.)*	

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 #	
Address						☐ Yes ☐ No	
City, State, Zip						Contact #	
Employer		Address					

City, State, Zip				**Contact #**	
Child Name:		**Child DOB:**		**Person ID:**	

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	

Child Name:		**Child DOB:**		**Person ID:**	

Employer		**Address**	
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