

Tennessee Department of Children's Services

## Initial Intake, Placement and Well-Being Information and History

Child Na	me:			Child DO	3:	Pei	rson ID:	
Initiated By:				Title:		Da	ite:	
Revised By:				Title:		Da	ite:	
Person Prov	viding Informatio	on to DCS:			Relationship to Child	/Youth: _		
Current insu	ırance coverage	e 🗌 Yes 🗌	☐ No ☐ Unkno	wn If yes	, provide details:			
Child/Yo	uth Inform	ation						
Name of Cl	nild/Youth:		E-mai	il Address:			SSN:	
DOB:	Sex:	Race	:	Hispanic:	Yes No	U.S. Citizen:	Yes Provide Bir	No Th Certificate
Suspected Heritage or If "Yes", ma	d/Youth Report to have Native r Tribal Affiliati ake a referral to CWA Referral to m form.	American on? o IICA team	Yes No	or custo	dicate which parent dian, Tribe, and n information:			
Child/Yout	h's Marital Stat	us (check one)	Never Marrie	ed Divo	orced		arried [	Separated
placements	s: ·			ustody epise	ode? If yes please list	dates ar	nd .	Yes No
	Descriptio		iid/Youtn					
	escription Date		i.	Primar Hair Color	y Language Spoken	Eva Calar		
Height Religion:		Weight	Identifying Nor Tattoos:			Eye Colo		
Special N	eeds/Disabilitie	es:						
Special M	edical Equipme	ent:						
	d Appointment vider, location, pt)	ss:						

Child	Name:				Child D	OB:				Person ID:	
				<b>_</b>							
Allergies/Adverse Reactions: Ves No  Medication: Describe reaction:											
	ation:										
Food:								be reac			
Insect	Sting:						Descri	be read	ction:		
Other							Descri	be read	ction:		
Medic	al mod	ified/Re	eligious diet?	s No	If yes, de	scrib	be				
Mod	icatio	nc. D	roscribad and C	)vor tho	Countor						
Medications: Prescribed and Over the Counter  Current medications (name, route, frequency, dosage & days of meds left)											
Curren	t meaic	ations	(name, route, jrequen	icy, aosage	& aays of m	ieas	iejt)				
Are m	eds giv	en in so	:hool?	] <sub>No</sub>   Whi	ch meds?						
Conse	nt sign	ed for p	sychotropic meds:	Yes	□ No □	] N/A	\	t med			
						] 19/7	appo	ointme	nt:		
	ster Pa ed med	irent dication	Yes No	Explain:							
			of Child Explain a	ny items c	hecked No	λw/F	Past in	"COM	MENT	S" section	
No	Now	Past	Of Cilia Explaine	in y items e	TICCKCU IVC	70071	No	Now	Past	3 300001	
			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 disorc	ler						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			Ī				Other developmental disabilities	
Child/	Youth i	s curre	ntly hospitalized:	Yes _	] No						
If yes, v	vhere a	nd why	:								

Child	hild Name: Child DOB: Person ID:											
	omments/Additional health information/ongoing health related services:											
Comm	ents/A	dditio	nal health info	rmation/ongoing	healt	h rela	ate	d servi	ces:			
Chile	dhoo	d Illn	esses									
No	Yes	App	orox date					No	Yes	Approx date		
				Measles							Chicken pox	
				German measles							Scarlet fever	
				Mumps							Rheumatic fever	
Trau	ıma S	cree	ning	·					•			
				lverse experiences.	Expla	in an	v ve	es ansv	vers in '	'COMMENTS" s	ection	
No	Yes				No	Yes						
		Neg	lect					Domes	tic viole	ence		
		Phy:	sical assault/ab	use				School	violend	:e		
		Sexi	ual assault/abu	se				Comm	unity vi	olence		
		Emo	tional abuse					Extrem	e inter	personal violen	ce	
		Trau	ımatic loss/sep	aration				Natura	l disast	er		
		Exte	nded illness/m	edical trauma				Impair	ed care	giver (substanc	e abuse/mental illness	5)
		Seri	ous injury					Other	trauma	, describe:		
H	las abu	se bee	n reported?	Yes No I	f no.	call	CP.	S 877-	237-0	026		
			nal health info									
Child	d Stre	ngth	)C									
Beh	avior		ental Heal	th History								
No	Now	Past										
		<u> </u>		r, if yes, describe								
		<u> </u>		if yes, describe	-l	-:1						
		<del>-  -</del>	_	r Association, if yes,								
		<u> </u>		ntion Seeking, if yes								
		<u> </u>		Statements, if yes, c		oe						
		<u> </u>		llties, if yes, describ								
		<u> </u>		operty, if yes, desci	ribe							
	<u> </u>			g, if yes, describe								
				ng, if yes, describe								
			Stealing, if ye									
			Runaway, if y									
			Hoarding, if y									
			Problems wit	h concentration and	d attei	ntion	if١	es de	scribe			

Child	Name	:		Child DOB:	Person ID:						
			Excessive Hyperactivity/does not re	spond 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 H	arm, if yes, de	escribe						
			Aggressive, dangerous or destructiv	e behaviors, if	yes, describe						
			Sexual aggression, if yes, describe								
			Had homicidal thoughts, if yes, desc								
			Had suicidal thoughts, if yes, describ	oe							
			Attempted suicide If yes, describe								
			Had other mental health or behavio		f yes, describe						
	Other mental health diagnosis, if yes, describe										
∐ac+	ha Chil	d/Vou	th received counseling or therapy?	∏ Ye	es 🗆 No						
	, where		threceived counseling of therapy:								
_			th had a Psychological Evaluation:	☐ Ye	es 🗆 No						
			thinad a raychological Evaluation. then, where?		110						
, ,	,		,								
Hast	he Chil	d/You	th been hospitalized for mental he	alth nrohlems	/acute hospitalization? Yes No						
			hen, where?	uten problems	res   No						
,	,										
Has t	he Chil	d/You	th/Family received in-home service	es? Yes	□ No						
	f 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											
			Trequency (7.3 per day/week/month)	Alcohol							
					ke/chew (circle one or both)						
				Marijuana	apor cigarettes						

Child	Child Name: Child DOB: Person ID:										
					Narcotics						
					Stimulants						
					Methamphet	tamine					
					Hallucinoger	ns					
					Steroids						
					Huffing						
					Ecstasy						
□ □ Street drugs, unknown											
□ □ □ Prescription drugs prescribed for another, specify:											
					Over-the-cou	unter medicat	ion, specify:				
					Other, specif	fy:					
Addi	tional	Comme	ents:	I							
			. 151 1 1								
Has	hild be	en ide	ntified as h	igh risk?			Yes	∐ No			
Has a Safety Plan been completed on child identified as high risk?											
Birth History (for all children)											
	Weigh			irth Length:		Full	term or	Premature	birth (<36 weeks)	weeks	
			e prenatal (		Yes No			or 1 <sup>st</sup> prenat	-		
Preg	nancy/	Birth c	omplication	ns:				•			
_	_		al substance		Yes No	Substan	ce and freq	juency:			
Birth	hospi	tal and	location:					-			
Min	or Fe	male	1	•							
	of 1 <sup>st</sup> P			Date of Las	t Period:						
	nancie			Live births		Full term		Premature	(# weeks)		
	arriage			Abortions		Currently	nregnant:	Yes	No If yes, due	date:	
IVIISC	urriuge	.3 π		Abortions	• π	Currently	pregnant.		II yes, due	uate.	
Does	the yo	uth ha	ve children	? Yes	☐ No If	f yes, answer					
Yout		ldren's	DOB	In DCS	Male/	Race		erson Child	Name of Child's	Contact	
	Name	S		Custody?	Female?			ith and	Other Parent	Information of	
				Yes 🗌	Male 🗌		Keiati	onship		Other Parent	
				No 📙	Female						
				Yes 📙	Male						
				No 🗌	Female 🗌						
				Yes 🗌	Male 🗌						
				No 🗌	Female 🗌						
Does	minor	paren	t have visit	ation with t	heir child(re	n)?  Yes	No No				

Child Name:	(	Child DOB:	Person ID:							
If yes, list any visitation restrictions:										
Gender and Sexual Identity										
Does the Child/Youth identify h	im/herself as gay, lesbia	an, transgender, or nor	<b>a-binary?</b> Yes No							
If yes, describe answer										
Sexual Activity										
Is child sexually active?	s No Use birth con	trol? Yes No	Method:							
•										
Dating Violence										
Has Child/Youth experienced co	ontrolling, abusive or ag	gressive behavior in a	dating relationship?	/es No						
If yes, explain:										
Medical										
Does the Child/Youth have a re	gular medical provider (	pediatrician, family do	ctor, etc.)?	No						
If yes, name of medical provide	r:		Date of last vis	it:						
Immunizations										
Are immunizations up-to-date?	Yes No Is	the immunization reco	rd available? Yes	] No						
Religious/medical exemption?	Yes No (parent	t/guardian must provide	a notarized statement)							
Dental										
Does the Child/Youth have a re	gular dental provider?	Yes Does the O	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 glas	ses? Yes No	Does the Child/Youth	wear contacts?	No						
If ves. name of vision provider:			Date of last visi	t:						

This concludes the Well-Being Section.

CS-0727, Rev. 6/24 RDA 11016

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

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CS-0727, Rev. 6/24 RDA 11016

	This i	nformation de	oes not go to	Health C	are P	rovider.					
		n and Indepe									
		duated high school		o	Пні	SET Studer	nt Home Schoo	oled			
		does the student a									
Stud	lent's ag	ge	Current grade			Student recei	ves special ed	lucation services	? Yes No		
If ye	s, name	the disability			I		•				
No	Yes	1 1 1 1 1 1 1 1 1	CED 1								
		Is the student takin									
		Does the student h			ol?						
		Is the student in a	n alternative schoo	l?							
		Is the student serv	ing a zero toleranc	e expulsion	(drugs,	weapons and/o	r assault)?				
	Is the student serving a suspension for issues other than zero tolerance? If yes, what is the reason and duration of suspension?										
Stud	lant str	engths (check all t	hat annly)		Areas	needing impr	ovement (che	ck all that apply)			
	/lathema		пас арргу)			athematics	orement (che	ck all that apply)			
Reading Reading											
A	thletics				At	hletics					
_=		ice in school			-=-	tendance in sch	ool				
	other, sp	ecify			Ot	her, specify					
		you would like to					linguent V	(outh only)			
		positional Informa		0113 011 1	outii	(Omaly/DC	iiiiqueiit i	outil only,			
	osition					Special Judge					
Curr	ent Dis	position Court									
		position Decision						Disposition Date			
		en or are you curi	ently on probation	on? Yes	5 N	o If yes, whe	re				
	ense Att	•									
		udication Type					Current A	djudication Date			
Adju	idicated	Charge - Current	and Previous			Date Occurred	Disposition Date	Disposition			

**Child DOB:** 

**Person ID:** 

CS-0727, Rev. 6/24 RDA 11016

**Child Name:** 

Child Name:	Child DOB:	Person ID:	
			5 . (6
Pending Charge	S	Court Date Set	Date (if yes)
		Yes No	
		Yes No	
		☐ Yes ☐ No	
Violation of Pro	bation (VOP) or Violation of Valid Court Order (VVCC	)) (explain if applicable)	
Narrative			
	tion Services Previously Offered to Ch		
Date	Туре	Outcome	
Safety (Unri	uly/Delinquent Youth only)		
	nt Allegations or Unruly Behaviors/Delinquency		
Other (explain)			
Narrative			
Strengths (Signs	of Cafatul		
	d Concerns (Signs of Risk include aggressive behavior	, arson, cruelty to animals, gang involv	rement, etc.)
•		, , ,	, ,
B) Domestic Vio	lence		
Narrative			
Studen other (Siene	of Cufety)		
Strengths (Signs	of safety)   d Concerns (Signs of Risk include aggressive behavior	arson cruelty to animals gang involv	vement etc)
, .teeus un	a control (5.6.00 of mon metade appressive beliavior	, a. z z, e. a z z z aao, g agvoi	

Child Name:	Child DOB:			Person ID:	
FSW Name		(	Contact #		
Office Addres	s				
Supervisor		(	Contact #		
	DCS / Provider Staff			Date	
and History. I f this information	receipt of the Intake, Placement, and Well-Being Infurther acknowledge my legal duty to maintain confident and history and any additional information I may ennessee Code Annotated §37-2-415, The Foster Par	dentiality of receive			
Act.	·	J			
	Foster Parent			Date	
	Foster Parent			Date	

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Child Name	:		Child DOB:		Person ID:				
	<del>*</del>								
Do no	t provide this	s section to the Fo	ster Parent o	or the Health Ca	re Provide	er.			
Una tha shild (V	outh boon adont	adı Oyas ONaı Wa	s the shild (Veuth	in Dormanont Cuar	dianchin:	Vac			
Has the child/Y	outh been adopt	ed: Yes No: Was	s the child/Youth	in Permanent Guard	aiansnip:	Yes   No			
		or Subsidized Permanent				- Finant Chaff			
(if yes, <u>immedia</u>	tely notify the Perr	manency Specialist, Child \	Weitare Benefits C	ounselor Regional and	d Central Office	e Fiscai Staπ).			
Adoption/Gua	rdianship Comple	eted by DCS: Yes	No (If no List N	lame of the Agency)					
Removal Date:									
New Placemen	t:								
Date of Placem	ent:								
Legal Custody I	)ate:								
Legal Custouy I	Jucc.	Adjudication Type	: Depende	ent and Neglect 🔲 U	Jnruly   Deli	inguent N/A			
Removal				5 <u> </u>	, _	. —			
County:		Brief Description:							
Removal /	Alcohol Abuse (Chi	ld);	rent);	er Inability to Cope du	ue to Illness or	Other; Child's			
		<del></del>				Housing;  Incarceration			
		osecution (only select upo		<del></del>	al Abuse (alleg	ed/reported);			
Relii	nquishment; 💹 S	exual Abuse (alleged/repo	rted);	<u>'</u>					
Removal Stree	t Address								
City		County		State	Zi	p Code			
			ship Exception R	equest					
Was KER appr	oved? Yes	No If yes, by whon	n?:						
	emporary or long		orary 🗌 long	term					
MSW Consult	was completed w	rith:							
Family Info	ormation								
Both parents	living?	Yes No If no	, date(s) of death	1:					
Household in	come to determin	ne IV-E eligibility: (includ	ing SS Ronofits S	SI for child AEDC E	odstamns Ch	aild Support etc ) If			
		ed, please indicate in wh	_		-	ina support, etc., ii			
Child/Yout	h Parent(s)/C	aretaker(s)							
Child/Youth Parent(s)/Caretaker(s) Indicate Parent/Caregiver's Preferred Method for Receiving Documents									
Birth Mother's					/ Caregiver	Yes No			
Email Address				☐ Yes	□ No				

DOB

**Social Security No.** 

**Maiden Name** 

Message Contact #

Child Name:				Child DOB:			Per	son ID:	
						1			
Address							Yes	No	
City, State, Zip								Contact #	
Employer				Add	dress				
City, State, Zip							C	Contact #	
Birth mother marrie	ed when child/Y	outh was b	orn?	Yes	No 🗌	Unab	le to Determin	e	
Birth mother ever be	een married?	☐ Yes [	☐ No	Unable to D	etermine		, where to whom?		
Birth mother ever be	een divorced?	☐ Yes [	☐ No	Unable to D	etermine		, where and n whom?		
Birth mother's race:									
Is there a father list	ed on the birth	certificate?	? \ \ \ \ \ \	es No					
Has DNA testing eve	er been done?	☐ Yes [	□No	If so, what we and where wa		lts			
Has there ever been the time of birth or a						Ye	s 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 Pa	rents	rried [	Separ	ated Div	vorced	□ o	ther		
Putative/Alleged Fa	ther's Name								
Email Address									
Social Security No.							DOB		
Address							<u> </u>		
City, State, Zip									
Employer	•				Addre	SS			
City, State, Zip									
Putative/Alleged Fa	ther's Race:								
Caregiver's Name (i	f different from	above)							
Email Address									
Social Security No.							DOB		
Address									
City, State, Zip									
Employer					Addres	s			

Child Name:		Child DOB:	Person II	D:
City, State, Zip				
<b>Relative Contact Perso</b>	n For Child/Yout	h (other than pare	nt)	
Relationship				
Child/Youth Siblings:				In Custody
Name	SSN	ров	Sex Race	☐ Yes ☐ No
Name	SSN	ров	Sex Race	Yes No
Name	SSN	DOB	Sex Race	Yes No
Name	SSN	ров	Sex Race	☐ Yes ☐ No
Name	SSN	ров	Sex Race	Yes No
Name	SSN	ров	Sex Race	Yes No
Name	SSN	ров	Sex Race	Yes No
Name	SSN	ров	Sex Race	☐ Yes ☐ No
Name	SSN	ров	Sex Race	☐ Yes ☐ No
Name	SSN	ров	Sex Race	☐ Yes ☐ No
Name	SSN	ров	Sex Race	☐ Yes ☐ No
Name	SSN	ров	Sex Race	☐ Yes ☐ No