

School Information:

Grade: _____ I.Q. _____

Last Tested: _____

(Please attach results)

I.E.P.: _____ Yes _____ No

(If yes, please attach)

Classroom Placement:

____ Regular ____ Mainstream

____ B.D. ____ L.D.

____ Alternative School ____ Homebound

Education Needs:

Name of Last School/Address/Contact Person:

Mother's Address:

Father's Address:

Mother's Telephone Number:

(Area Code) _____

Father's Telephone Number:

(Area Code) _____

History of CPS Involvement:

____ Yes ____ No

Parental Rights:

____ Not terminated ____ Father's terminated
____ Mother's terminated ____ Both terminated

Custodial Status of Child:

____ Both Parents ____ Relative
____ Mother Only ____ DHHR
____ Father Only ____ Other

Service Providers Involved with Family/Client

Please List Contact Person

1. Children's Services: _____
2. Mental Health: _____
3. Juvenile Court: _____
4. Special Education: _____
5. Vocational School: _____
6. Human Services: _____
7. Hospital: _____

Client's Permanency/Discharge Goal/Plan:

Medical Status:

Immunization Records: ____ Yes ____ No
(If yes, please attach)

Medical Coverage:

A. _____
Medical Card Number

or B. _____
Parent Insurance

or C. _____
Referring Agency

Current Medications (Name, Dose):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Date of Last Medical Exam: ____/____/____ (With whom): _____

Date of Last Dental Exam: ____/____/____ (With whom): _____

Date of Last Optical Exam: ____/____/____ (With whom): _____

Does client wear glasses: ____ Yes ____ No

Date of Last Psychological: ____/____/____ (With whom): _____ Diagnosis: _____

Psychiatric Exam: ____/____/____ (With whom): _____ Diagnosis: _____

Medical Needs:

Psychological/Psychiatric Needs:

Visitation Arrangements: (Including siblings, extended family, family friends):

Please List Family Members/Age/Relationship/Current Living Arrangement

Member	Age	Relationship	Current Living Arrangement
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____

PLEASE IDENTIFY WHETHER THE CHILD HAS THE FOLLOWING BACKGROUND FACTORS

Y= YES; N = NO; U = UNKNOWN

- | | |
|---|--|
| <input type="checkbox"/> Interpersonal conflict with family members | <input type="checkbox"/> Mother lives in the home |
| <input type="checkbox"/> Drug/Alcohol dependency with family member | <input type="checkbox"/> Father lives in the home |
| <input type="checkbox"/> Relative is head of household | <input type="checkbox"/> Step-parent lives in the home |
| <input type="checkbox"/> Grandparent is head of household | <input type="checkbox"/> Siblings live in the home |
| <input type="checkbox"/> Family moves frequently | <input type="checkbox"/> Siblings live in foster home |
| | <input type="checkbox"/> Siblings live in Residential facility |
| | <input type="checkbox"/> Siblings live in kinship care |

Child Behaviors: Y = YES; N= NO; U = UNKNOWN

- | | | |
|---|---|---|
| <input type="checkbox"/> Victim of Neglect | <input type="checkbox"/> Self mutilating | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Victim of Physical Abuse | <input type="checkbox"/> Fire Setting | <input type="checkbox"/> Homicidal |
| <input type="checkbox"/> Victim of Sexual Abuse | <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Steals |
| <input type="checkbox"/> Victim of Psychological Abuse | <input type="checkbox"/> Needs constant supervision | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Sexual perpetration against others | <input type="checkbox"/> Scapegoating | <input type="checkbox"/> Guilty (obsessive) |
| <input type="checkbox"/> Sexually active | <input type="checkbox"/> Controlling/manipulative | <input type="checkbox"/> Denial (contant) |
| <input type="checkbox"/> Physically aggressive | <input type="checkbox"/> Grieving (unresolved) | <input type="checkbox"/> Nightmares/nightterror |
| <input type="checkbox"/> Verbally aggressive | <input type="checkbox"/> Good communication skills | <input type="checkbox"/> Emotional Disorder |
| <input type="checkbox"/> Unruly/ungovernable | <input type="checkbox"/> Understands own needs | <input type="checkbox"/> Good hygiene skills |
| <input type="checkbox"/> Truancy | <input type="checkbox"/> Drug use/abuse/addiction | <input type="checkbox"/> Enuresis |
| <input type="checkbox"/> Destruction of property | <input type="checkbox"/> Alcohol use/abuse/addiction | <input type="checkbox"/> Encopresis |
| <input type="checkbox"/> Passive | <input type="checkbox"/> Smokes cigarettes | <input type="checkbox"/> Leader |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Uses smokeless tobacco | <input type="checkbox"/> Hast Friends |
| <input type="checkbox"/> Suicidal | <input type="checkbox"/> Prescribed psychotropic medication | |
| <input type="checkbox"/> Runaway | | |

SPECIAL NEEDS:

- Speech
- Occupational Therapy
- Physical Therapy
- Optical needs
- Auditory assistance
- Special dietary needs
- Other (specify):

LIST STRENGTHS OF CHILD:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

