Initial Intakes Assessment

OMB 0970-#### [Valid through MM/DD/2020]

UAC Basic Information

First Name:

Last Name:

AKA:

Status:

Date of Birth:

Gender:

A No.:

LOS:

Age:

Current Program:

Child's Country of Birth:

Admitted Date:

Initial Intakes Assessment

INSTRUCTIONS: A staff member trained in the use of this form completes it within 24 hours of the child or youth's admission at the care provider facility. The staff member completing this form must be trained to ask and gather sensitive information in a child-friendly and culturally appropriate manner. This assessment will gather basic identifying information, identify any immediate medical or mental health needs the child or youth has, ensure that the needs are appropriately met, and inform the child or youth's initial housing/bed assignment.

Child's Arrival Date/Time:

Intake Interview Date/Time:

Child's Primary Language:

Intake conducted in what language:

Date of departure from home country:

Date of Arrival in the US (approx.):

Family Information

Do you know anybody in the U.S.? Include relative and non-relative contacts in this section.

Name	Relationship	Address	Phone

Is there someone we can contact to let them know you are here?

Medical

If any observed or reported medical concerns are checked in the section below, please immediately report these to the Clinician, Lead Case Manager, Program Director, Shift Supervisor, and/or any on-call medical staff member for further guidance on the need to seek immediate medical care.

Have you experienced any physical/medical problems today or in the last 30 days? ○ Yes ◉ No

If yes, please explain:

Have you experienced any physical/medical problems? ○ Yes ◉ No

If yes, please explain:

Do you have any allergies? ○ Yes ◉ No

If yes, please explain:

Do you have any special dietary needs? ○ Yes ◉ No

If yes, please explain:

Are you currently taking any prescribed or other medication? If yes, list below. Other medication may include herbal remedies, over-the-counter remedies etc.

○ Yes ◉ No

Medication

Medication	Dose	Purpose

Observable or reported medical concerns (Check all that apply).

Concern	Yes/No	
Coughing	○ Yes ◉ No	
Difficulty Breathing	○ Yes ◉ No	
Dehydration	○ Yes ◉ No	
Dizzines	○ Yes ◉ No	
Confusion	○ Yes ◉ No	
Fever	○ Yes ◉ No	
Pregnant	○ Yes ◉ No	
Exhaustion	○ Yes ◉ No	
Lice	○ Yes ◉ No	
Injuries	○ Yes ◉ No	
Bruises	○ Yes ◉ No	
Burns	○ Yes ◉ No	
Scabies	○ Yes ◉ No	

Vomiting	○ Yes ◉ No	
Abdominal Pain	○ Yes ◉ No	
Coughing Blood	○ Yes ◉ No	
Nausea	○ Yes ◉ No	
Skin lesions/rash	○ Yes ◉ No	
Severe/persistent headache	○ Yes ◉ No	
Jaundice (Yellowing of the skin/whites of eyes)	○ Yes ◉ No	
Neurological symptoms (Spasm, tics, uncontrollable movements, paralysis or numbness of any part of the body)	○ Yes ◉ No	
Others(list)	○ Yes ◉ No	If Yes, specify:

If injuries, wounds, bruises present, describe them and how they occurred:

List of other medical concerns:

Have you ever been to a doctor or stayed in a hospital? ○ Yes ◉ No

If yes, please list any visit or stay for any reason. Also include visits to other healers or alternative treatment providers:

Do you have a history of tuberculosis? ○ Yes ◉ No

If yes explain:

Do you have a history of seizures of convulsions? ○ Yes ◉ No

If yes explain:

Do you have any scars, birthmarks, or tattoos? ○ Yes ◉ No

If yes explain:

Mental Health (Check all that apply)

If the child answered "Yes" to any of the below mental health questions and/or if any concerning behaviors or emotions were observed or reported, immediately report your concerns to the Clinician, Lead Case Manager, Program Director, or Shift Supervisor for further guidance on the need to seek mental health care.

Concern	Yes/NO
Tried to hurt yourself?	○ Yes ◉ No
Had urges to beat, injure or harm someone?	○ Yes ◉ No
Harmed anyone?	○ Yes ◉ No
Thought of attempting suicide or hurting yourself?	○ Yes ◉ No
Attempted suicide?	○ Yes ◉ No
Heard voices that others do not?	○ Yes ◉ No
Seen things or people that others do not see?	○ Yes ◉ No
Had trouble controlling anger or violent behavior?	○ Yes ◉ No
Are you having thoughts of harming yourself or someone else?	○ Yes ◉ No

Please explain any checked answers above:

Observable emotional concerns (Check all that apply)

Concern	Yes/NO	
Cooperative	○ Yes ◉ No	
Uncooperative	○ Yes ◉ No	
Alert	○ Yes ◉ No	
Distracted	○ Yes ◉ No	
Calm	○ Yes ◉ No	
Excited	○ Yes ◉ No	
Nervous	○ Yes ◉ No	
Agitated	○ Yes ◉ No	
Confused	○ Yes ◉ No	
Sad	○ Yes ◉ No	
Angry	○ Yes ◉ No	
Other	○ Yes ◉ No	If Yes, specify:

Are you having thoughts of harming yourself or someone else?

Safety Assessment

If the child answered "Yes" to any of the below safety assessment questions, immediately report concerns to the Clinician, Lead Case Manager, Program Director, or Shift Supervisor for further guidance on how to ensure the child's safety.

Do you feel safe now? ○ Yes ○ No

Explain if No:

Do you fear that someone will harm you? ○ Yes ○ No

Explain if yes:

Explain to the child where the child's room will be located in the facility, the number of potential roommates, the age and sex of the roommates, and the bathroom and shower area ○ ○

associated with the potential room assignment. After having explained this, does he or she identify any specific fears about this potential housing assignment? Yes No

Do you need anything right now?

	INTERVIEWER SUMMARY OF CRITICAL ISSUES THAT NEED IMMEDIATE ATTENTION: List any issues rated above as urgent or significant and your actions to address them. Deliver this form to the Lead Case Manager, Clinician, or other SUPERVISOR designated to follow-up care.		ACTIONS TAKEN: Each action should correspond to the issues noted at left.
1		1	
2		2	
3		3	

Staff Signature: **Date:**

Staff Name: **Staff Title:**

Translator's Signature: **Date:**

Translator's Name: **Language:**